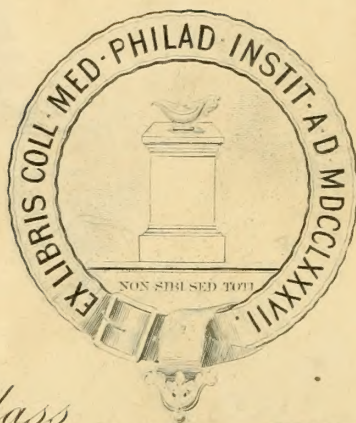




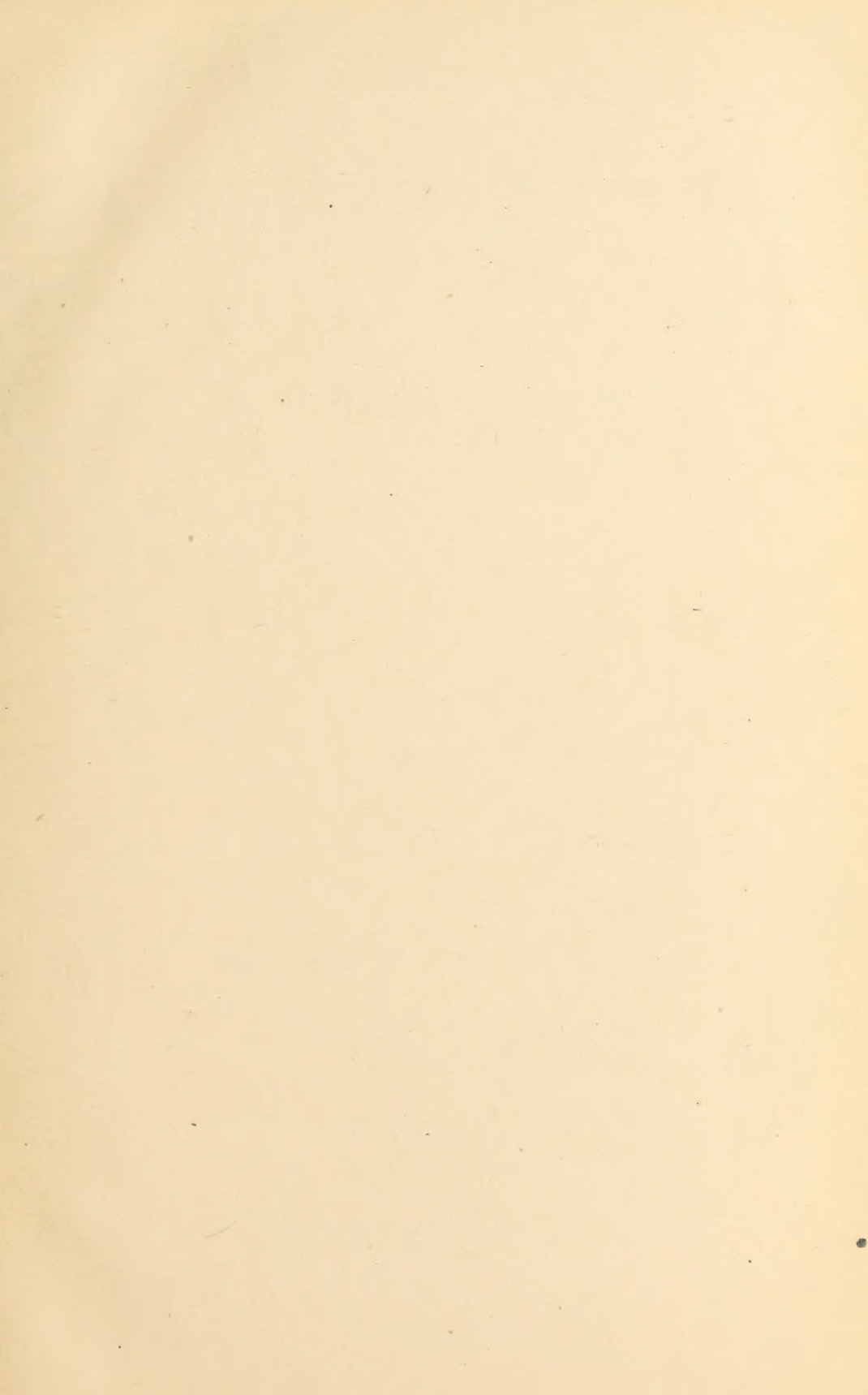
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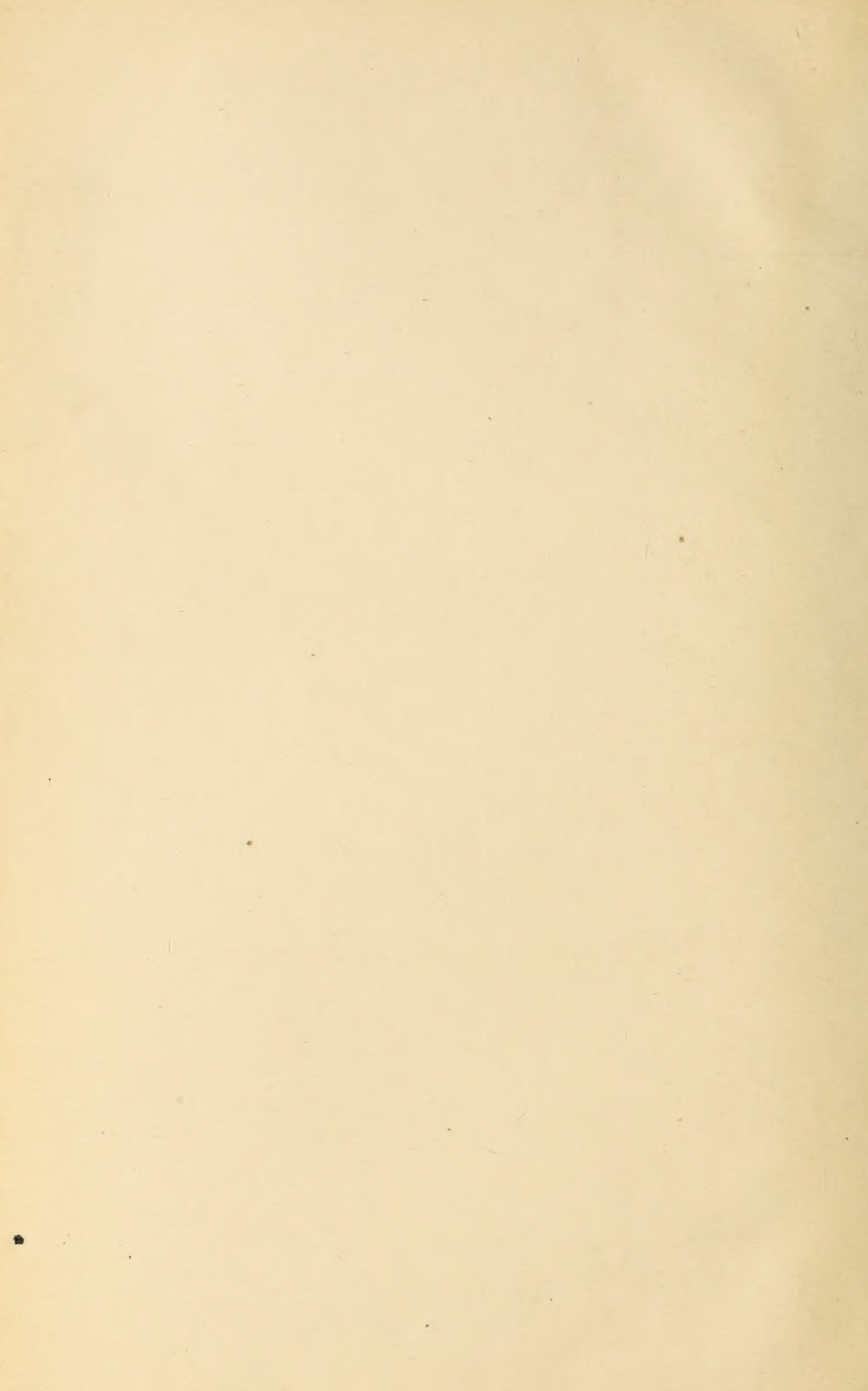


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CONTENTS OF VOLUME XV.

| | |
|--|----------|
| Association Meeting in Milwaukee, The, | 494 |
| Acardiacus Amorphus, with a Heart, | 270 |
| Advertise? Why not, | 355 |
| Alleged Insanity, Things to be Considered in Cases of. By R. A. Prichard, M. D., | 129 |
| Alopecia. By John V. Shoemaker, A. M., M. D., | 281 |
| Alumni Association, The, | 238 |
| American Medical Editors Association, | 319 |
| Angina Pectoris, The French Treatment of, | 353 |
| Appendicitis Gangrenosa; Operation; Recovery. By H. M. Goodman, M. D., | 450 |
| Artificial Eczema, | 34 |
| Ascites, Milky, | 487 |
| Asepsis that Is Not Asepsis, | 437 |
| BARBOUR, JOHN FORD, M. A., M. D., | 1 |
| Bilious Fever, not Yellow Fever, | 190 |
| Biographical Notices, Some Prospective, | 357 |
| BLUE, W. R., M. D., | 508 |
| Bulletin, Pan-American Congressional, | 278 |
| BULLOCK, T. S., M. D., | 457 |
| By-Laws, New, Pan-American Medical Congress, | 277 |
| Cancer, | 436 |
| Cancer Coccidia, | 119 |
| Cancer Parasite, The, | 359 |
| CARPENTER, J. G., M. D., | 81, 401 |
| Cataract, Spontaneous Cure of Complete Senile, | 114 |
| CECIL, JOHN G., B. S., M. D., | 245, 453 |
| Cerebral Syphilis. By J. E. Hays, M. D., | 7 |
| CHEATHAM, WM., M. D., | 241, 361 |
| CHENOWETH, JAMES S., M. D., | 47 |
| Chloroform Anesthesia and Administration. By P. Guntermann, M. D., | 364 |
| Chlorosis, Therapy of, | 108 |
| Cholera, | 110 |
| Cholera Asiatica, Experiments Relative to the Etiology of, | 491 |
| Cholera, Asiatic, The Antiseptic Prophylaxis of. By George Cowan, M. D., | 327 |
| Cholera Bacillus on Various Food-stuffs, The Viability of the, etc., | 486 |
| Cholera, Disinfection in, | 354 |
| Cholera Infantum, A Report on. By Lyman Beecher Todd, M. D., | 497 |
| Cholera in Hamburg, | 80 |
| Cholera in the Spring? | 76 |
| Cholera: The Differences in the Behavior of Cholera in the Different Epidemics, | 107 |
| Chorea, Huntingdon's, | 274 |
| Cigar Ends for Sale, | 40 |
| Cincinnati Correspondence, | 358 |
| "Conglutinatio Labiorum," | 152 |
| Constipation. By Cornelius Skinner, M. D., | 410 |
| Corrosive Sublimate as a Germicide, | 192 |
| COWAN, GEORGE, M. D., | 327 |

| | |
|--|-----------------------------|
| Croup, Diphtheria, and Tracheotomy. By R. A. Prichard, M. D., | 321 |
| Deaths in the Profession Abroad, | 120 |
| Deaths of Eminent Medical Men, | 239 |
| Departure, Our New, | 35 |
| Dermatitis due to Opium, | 193 |
| Diabetes Mellitus after Extirpation of Pancreas, | 34 |
| Diagnosis of Love, The, | 535 |
| Diphtheria, Circular of Information Concerning the Use of Bacterial Cultures by the Health Department for the Diagnosis of, | 493 |
| Diseases of Children, Section on, The Pan-American Medical Congress, | 399 |
| Doctor, The, a Gentleman. By T. B. Greenley, M. D., | 166 |
| Enuresis Diurna. By F. C. Simpson, M. D., | 369 |
| Epilepsy, Sleep Movements of, | 234 |
| Euthanasia, M. Renan on, | 39 |
| EVANS, T. C., M. D., | 289 |
| Fetus, A Gigantic Dead-born, | 270 |
| Ford's Theater, | 536 |
| Functional Nervous Disorders, A Study of Some of the Drugs Used in, | 112 |
| Fungi as Food-stuffs, | 272 |
| Genito-Urinary Surgery, Report on. By W. R. Blue, M. D., | 508 |
| Gestation, Ectopic, | 191 |
| GOODMAN, H. M., M. D., | 450 |
| GRANT, T. P., M. D., | 41 |
| GREENLEY, T. B., M. D., | 166 |
| GREEN, W. O., M. D., | 441 |
| GUNTERMANN, P., M. D., | 364 |
| Gynecology, Report on. By John G. Cecil, B. S., M. D., | 453 |
| HAYS, J. E., M. D., | 7 |
| Hypnotism and the Hypnotic Medium, | 153 |
| Hysteria in Children, | 197 |
| Immigration Question, The, | 79 |
| Infection, Hereditary, | 232 |
| In Memoriam: Charles H. Spilman, of Harrodsburg, Ky. By A. D. Price, M. D., | 413 |
| Inoculation, Anti-rabic, of Dogs and a Cow, | 239 |
| International Congress of Charities, Correction, and Philanthropy, The, | 157 |
| Intussusception, | 159 |
| Iodide of Strontium, The, | 488 |
| Jaundice, The Nervous Origin of, | 74 |
| Kidney, Large Cyst of; Nephrectomy; Recovery. By L. S. McMurtry, M. D., | 515 |
| Laparotomy, Exploratory, A Remarkable Instance of Curative Effect of, | 315 |
| LARRABEE, JOHN A., M. D., | 208 |
| LAWRENCE, CHARLES B., M. D., | 331 |
| Lemonade as a Vehicle for Chloral, | 440 |
| LEONHARDT, J. S., M. D., | 248 |
| Leptothrix Mycosis of the Tonsil, Pharynx, and Base of Tongue. By William Cheatham, M. D., | 361 |
| Liquor Habit, The. By C. T. Pope, M. D., | 519 |
| Location of Respiratory Center, Experiment in a New-Born Child in Regard to, | 109 |
| Locomotor Ataxy with Charcot's Joint Disease, Two Cases of, | 156 |
| London Letter, | 31, 104, 267, 350, 433, 530 |
| Long Term of Study, | 439 |
| MCDERMOTT, T. L., M. D., | 84 |

| | |
|---|--------------------------------------|
| McMURTRY, L. S., M. D., | 169, 515 |
| Measles, Inoculation of, | 495 |
| Medical Meetings, Interest in, | 317 |
| Medicine, John Wesley in, | 194 |
| Menthol, Direct Application of to the Stomach, | 436 |
| Miss Cobbe and Lord Tennyson, | 39 |
| MUENCH, ALBERT, Ph. G., M. D., | 121 |
| Myxedema, Thyroid Grafting in, | 320 |
| Nasal Spray, What is the Sphere of the? By T. C. Evans, M. D., | 289 |
| Nervous Affections, Subcutaneous Injections of Phosphate of Soda in, | 75 |
| Neuralgia, Brachial, due to Exostosis of the First Rib, | 199 |
| Neurasthenia. By J. S. Leonhardt, M. D., | 248 |
| New Law Regulating the Practice of Medicine in Kentucky, The, | 393 |
| New York Academy of Medicine—Section on Orthopedic Surgery, | 132 |
| Obstetrical Don'ts, | 270 |
| Obstetrics, | 148 |
| Obstetrics, Report on. By T. S. Bullock, M. D., | 457 |
| OLDHAM, JOHN Y., M. D., | 503 |
| Ophthalmology, Some Notes on the Study of. By J. G. Carpenter, M. D., | 81 |
| Otitis, Acute Migratory, | 354 |
| Otology, | 189 |
| Ovarian Tumor during Pregnancy, A Case of, | 271 |
| Ovariectomy, Some Complications of. By L. S. McMurtry, M. D., | 169 |
| PALMER, E. R., M. D., | 161 |
| Pancreatic Disease, | 36 |
| Paralysis of Laryngeal Muscles, with Cases. By Wm. Cheatham, M. D., | 241 |
| Physician's Life, The Incidents and Exigencies of the. By W. O. Roberts, M. D., | 201 |
| Pleurisy, Suppurative Diaphragmatic, and Cerebral Abscess, | 198 |
| Pleurisy, The Bacteriology of Acute, | 273 |
| Pneumonia, Cardiac Stimulation in. By John A. Larrabee, M. D., | 208 |
| Pneumonia, Croupous, Cardiac Stimulation in, | 396 |
| Pneumonia, Digitalis in, | 239 |
| Poisoning by "Infant's Cordial," | 79 |
| Poisoning, Carbonic Oxide, | 160, 197 |
| Poisoning, Hyoscyamus and Atropine, | 74 |
| POPE, C. T., M. D., | 519 |
| Preventable Forms of Disease. By John Ford Barbour, M. A., M. D., | 1 |
| PRICE, A. D., M. D., | 413 |
| PRICHARD, R. A., M. D., | 44, 129, 321 |
| Proof of Death, The, | 439 |
| Pylorectomy, | 113 |
| Pyrozones, On the, | 486 |
| Recent Advances in Ophthalmology, Report on the. By John Y. Oldham, M. D., | 503 |
| Rectal Diseases, Report on. By W. O. Green, M. D., | 441 |
| Remarkable Surgery, | 533 |
| Reviews and Bibliography, | 72, 99, 146, 229, 347, 430, 481, 529 |
| Richmond Academy of Medicine and Surgery, Proceedings of the, | 60 |
| Rigor Mortis Forensically Considered. By R. A. Prichard, M. D., | 44 |
| ROBERTS, W. O., M. D., | 201 |
| Salophen, the New Remedy for Acute Rheumatism, | 399 |
| Sciatica. By Charles B. Lawrence, M. D., | 331 |
| Scirrhus, A Case of, Treated by Internal Medication. By T. P. Grant, M. D., | 41 |

| | |
|---|---|
| Shechita, The Jewish, | 117 |
| SHOEMAKER, JOHN V., A. M., M. D., | 281 |
| SIMPSON, F. C., M. D., | 369 |
| SKINNER, CORNELIUS, M. D., | 410 |
| Society, Cincinnati Obstetrical, | 343 |
| Society, The Kentucky State Medical, | 275, 355, 393, 462, 489, 522 |
| Society, The Louisville Clinical, | 96, 141, 172, 253, 292, 333, 383 |
| Society, The Louisville Medico-Chirurgical, | 11, 87, 181, 213, 372, 417 |
| Society, The Louisville Surgical, | 21, 50, 218, 303 |
| Southern Medical College Association, The, | 238, 397 |
| Special Notices, | 40, 80, 120, 200, 240, 280, 360, 400, 440, 496, 536 |
| Spleen, Enlarged, in Children, | 232 |
| Strumous Cicatrices of the Neck, Treatment of, | 34 |
| Suprapubic Cystotomy, Technique of. By James S. Chenoweth, M. D., | 47 |
| Surgery, Conservative, of To-day in Obstetrics, Abdominal, and Pelvic Work. By J. G. Carpenter, M. D., | 401 |
| Surgery, The Advancement of, | 115 |
| Syphilis, Treatment of. By Albert Muench, Ph. G., M. D., | 121 |
| Therapeutics, Section on, of the Pan-American Medical Congress, | 277 |
| Tight Lacing, The Consequences of, | 319 |
| TODD, LYMAN BEECHER, M. D., | 497 |
| Trional and Tetronal as Hypnotics, | 316 |
| Tumors, Cerebellar, and the Knee-jerk, | 233 |
| University of Louisville, | 235 |
| Urethral Surgery, The Present Status of. By E. R. Palmer, M. D., | 161 |
| Vaginitis, Specific. By John G. Cecil, B. S., M. D., | 245 |
| Varicocele. By T. L. McDermott, M. D., | 84 |
| Writing, Upright and Sloping, | 199 |
| Xanthoma Diabeticorum, | 488 |

CONTENTS OF VOLUME XVI.

| | |
|---|----------|
| Abdominal Surgery, Cases in, with Remarks. By David Barrow, M. D., | 15 |
| Acute Broncho-Pneumonia and Bronchitis in Children, The Differentiation of. By Henry E. Tuley, M. D., | 146 |
| Affections of the External Auditory Canal. By S. G. Dabney, M. D., | 449 |
| Alcoholism, The Modern Treatment of, | 165 |
| American Disease, The. By J. W. Irwin, M. D., | 89 |
| American Medical Diplomas, | 367 |
| American Surgical Association, The, | 87 |
| Amputation at the Hip-joint. By G. P. Hachenberg, M. D., | 453 |
| Appendicitis, | 248 |
| Arsenic in Epithelioma, | 285 |
| Articular Affections in Syringomyelia, | 524 |
| Aseptic Surgery for the Country Practitioner. By James B. Bullitt, M. D., | 369 |
| Bacillus Billet-de-Banquus, | 487 |
| Bacteria of the Surface, The, | 517 |
| Bacteriology: A Report. By Louis Frank, M. D., | 380 |
| BAILEY, WILLIAM, M. D., | 209 |
| BARBOUR, P. F., A. B., M. D., | 329 |
| BARROW, DAVID, M. D., | 15 |
| Bicycle Kyphosis, | 527 |
| Borden Trial, The, | 247 |
| BROWN, W. SYMINGTON, M. D., | 336 |
| BULLITT, JAMES B., M. D., | 369, 496 |
| BULLOCK, THOMAS S., M. D., | 263 |
| Cancer Cure, A New, | 83 |
| Cancer, its Etiology and Treatment. By W. L. Rodman, M. D., | 409 |
| CARTLEDGE, A. M., M. D., | 292 |
| Charcot, Jean Martin, | 206 |
| CHEATHAM, WM., A. B., M. D., | 175 |
| Chloralose, | 481 |
| Chronic Inflammation of the Tonsils. By L. S. Givens, M. D., | 492 |
| Cicatricial Stricture of Pylorus; Pyloroplasty. By A. M. Cartledge, M. D., | 292 |
| Clonic Spasm of the Cervical Muscles. By H. A. Cottell, M. D., | 489 |
| Conservative Operations on the Ovaries, Tubes, and Uterus, | 287 |
| COOMES, M. F., A. M., M. D., | 134 |
| COTTELL, H. A., M. D., | 489 |
| COWAN, HARRY J., M. D., | 24 |
| Craniectomy, | 248 |
| Credulity of the Medical Profession. By T. B. Greenley, M. D., | 418 |
| DABNEY, S. G., M. D., | 212, 449 |
| Death of William H. Galt, M. D., | 282 |
| Death of William Mandeville Griffiths, M. D., | 523 |
| Disaster Happily Averted, A., | 322 |
| Distinctive Title, The, | 403 |
| Doctor, The, a Gentleman, | 87 |
| Doctor, The, and the Cook, | 447 |

| | |
|---|-----------------------------|
| Doctor's Lament to His Lady-Love, The, | 526 |
| Electricity Arising from Gas and Water-pipes, | 447 |
| Electro-Therapeutics and Suggestion Therapeutics, | 442 |
| Ergot in Labor and Abortion. By F. M. Greene, M. D., | 49 |
| Erratum, | 88 |
| Eruption, Varioliform, After Vaccination, | 281 |
| Etiology and Pathology of Intra-Pelvic Inflammation, The, Illustrated by Specimens and Cases. By L. S. McMurtry, M. D., | 129 |
| EVANS, T. C., M. D., | 9 |
| Expert Surgery, The Luxury of, | 488 |
| Eye Diseases, Some Hereditary and Congenital. By J. Morrison Ray, M. D., | 141 |
| FRANK, LOUIS, M. D., | 380 |
| Ganglion, | 519 |
| GIVENS, L. S., M. D., | 492 |
| GRANT, H. HORACE, M. D., | 289 |
| GREENE, F. M., M. D., | 49 |
| GREENLEY, T. B., M. D., | 169, 418 |
| Guaiacol, Carbonate of, | 207 |
| Gynecology and Abdominal Surgery, Section of, Pan-American Medical Congress, | 88 |
| HACHENBERG, G. P., M. D., | 453 |
| Hardwar Fair, | 83 |
| Hay-Fever, A Means of Relief in, | 483 |
| Heart Therapy. By William Bailey, M. D., | 209 |
| Hemorrhages, Renal and Vesical. By R. A. Prichard, M. D., | 179 |
| Hewitt, Graily, | 206 |
| Hip-joint, Amputation at the, | 484 |
| Homicidal Monomaniac, The, | 362 |
| Hypnotism, | 446 |
| Identity of the Streptococcus Pyogenes and the Streptococcus of Erysipelas, The, | 361 |
| Interlobar Pleurisy, | 520 |
| Intestinal Anastomosis by a New Device. By H. Horace Grant, M. D., | 289 |
| Intubation of the Larynx and Esophagus. By Wm. Cheatham, A. B., M. D., | 175 |
| Iritis, Superiority of Cocaine Over Other Mydriatics in. By P. R. Taylor, M. D., | 63 |
| IRWIN, J. W., M. D., | 89 |
| Is Excision of Chancre a Justifiable Operation? By O. H. Reynolds, M. D., | 61 |
| KELCH, ALLEN H., M. D., | 296 |
| KEMPF, EDWARD J., M. D., | 218 |
| Legal Effect of Accepting an Amount Less than Bill Rendered, | 82 |
| LEONHARDT, J. S., M. D., | 249 |
| Lingual Tonsil, So-called—Some Diseases of the Glandular Tissues at the Base of the Tongue. By J. Morrison Ray, M. D., | 97 |
| Long-Continued Bladder Drainage, | 360 |
| London Letter, | 79, 119, 241, 351, 478, 506 |
| MARSHALL, EWING, M. D., | 299 |
| McMURTRY, L. S., M. D., | 129 |
| Meat-Eating and Bad Temper, | 82 |
| Mechanical Violence in the Treatment of Diphtheria, | 444 |
| Medical Practice Act, The New, | 127 |
| Medical Practice Law, The New, and the Secular Press, | 324 |
| Medical Profession of Kentucky, To the, | 407 |
| Medical Progress, | 323 |
| Medicine and Surgery, History of, in Dubois County, Ind. By E. J. Kempf, M. D., | 218 |

| | |
|--|----------------------------------|
| Melancholia. By P. F. Barbour, A. B., M. D., | 329 |
| Methylene Blue in Cancer, | 280 |
| Microbes: A Review. By James Weir, Jr., M. D., | 254 |
| Murderous Crank Again, The, | 521 |
| Mydriatics: Use and Abuse in Ophthalmic Practice. By S. G. Dabney, M. D., | 212 |
| Mystery of Chronic Contracted Kidney, The, | 326 |
| Myxedema and Its Treatment, | 244 |
| Nasal Surgery, Report on, with Illustrated Cases. By M. F. Coomes, A. M., M. D., | 134 |
| Naso-Pharynx in Measles and Scarlet Fever, The. By J. A. Stucky, M. D., | 57 |
| New Medical Journals, Two, | 527 |
| New York's Milk Supply, | 488 |
| New York State Association of Railway Surgeons, The, | 408 |
| Obesity and Fatty Degeneration, Treatment of, | 161 |
| O'BRIEN, J. D., M. D., | 92 |
| Otology, Report on. By T. C. Evans, M. D., | 9 |
| PALMER, E. R., M. D., | 180 |
| Pan-American Medical Congress, The, | 125, 204 |
| Pasteur's Anti-Rabic Inoculation, Present Status of. By J. S. Leonhardt, M. D., | 249 |
| Pasteur's Hydrophobia Cure a Failure, | 45 |
| Pediatrics, | 40, 121, 238, 318, 354, 439, 509 |
| Peritonitis, Case of Suppurative, Laparotomy, Recovery. By W. A. Quinn, M. D., | 215 |
| Pertussis, Bromoform in, | 84 |
| Phenosalyl, | 361 |
| Physical Exercises and Fencing, | 366 |
| Physiology of Weariness, The, | 327 |
| Physiology, Original Studies in. By J. D. O'Brien, M. D., | 92 |
| Placenta Prævia, | 281 |
| Poisoning by Amyl Nitrate, | 323 |
| PRICHARD, R. A., M. D., | 179 |
| Progress of Cremation, The, | 364 |
| Prostate, Treatment of Enlarged, | 83 |
| PURDOM, J. FULTON, M. D., | 375 |
| Quarantine, | 288 |
| QUINN, W. A., M. D., | 215 |
| RAY, J. MORRISON, M. D., | 97, 141 |
| Rectal Hemorrhages in Women. By W. Symington Brown, M. D., | 336 |
| Relapsing Infective Jaundice, | 525 |
| Relations of Dyspepsia to Pulmonary Tuberculosis, | 284 |
| Report of Two Clinical Cases, A. By James B. Bullitt, M. D., | 496 |
| Report Your Failures, | 44 |
| Rest in Bed, | 163 |
| Restoration of Hearing to the Deaf, The, | 443 |
| Reviews and Bibliography, | 77, 158, 236, 276, 316, 437, 474 |
| REYNOLDS, O. H., M. D., | 61 |
| ROBINSON, F. BYRON, M. D., | 333 |
| RODMAN, W. L., M. D., | 1, 409 |
| Rôle of the Posterior Urethra in Chronic Urethritis, The, | 358 |
| "Running Amock." By Ewing Marshall, M. D., | 299 |
| Sacro-Pubic Hernia. By F. Byron Robinson, M. D., | 333 |
| Salophen in Acute Rheumatism, | 408 |
| Scottish Medicine in the Days of Queen Mary, | 321 |
| SMITH, FRANK TRESTER, A. M., M. D., | 455 |

| | |
|---|--|
| Society, The Kentucky State Medical, | 26, 65, 86 |
| Society, The Louisville Clinical, | 102, 154, 339 |
| Society, The Louisville Medico-Chirurgical, | 149, 194, 224, 265, 302, 388, 458, 498 |
| Society, The Louisville Surgical, | 107, 183, 425 |
| Society, The Ohio State Medical, | 328 |
| Some Clinical Notes. By Allen H. Kelch, M. D., | 296 |
| Special Form of Phlegmon of the Neck, A., | 327 |
| Special Notices, | 48, 128, 168, 208, 248, 288, 328, 368, 448, 488, 528 |
| Splenectomy for Scirrhus Carcinoma: Death from Shock. By H. J. Cowan, M. D., | 24 |
| Statistics of Kentucky for 1892, Vital and Mortuary. By T. B. Greenley, M. D., | 169 |
| STUCKY, J. A., M. D., | 57 |
| Subdiaphragmatic Abscesses Containing Air, | 279 |
| Sulphonalism, | 482 |
| Sun in Surgery, The, | 286 |
| Sweetbread, The True, | 247 |
| Syphilis, Care of Upper Air-passages in Treatment of. By E. R. Palmer, M. D., | 180 |
| TAYLOR, P. RICHARD, M. D., | 63 |
| Treatment of Loss of Sexual Power by Ligation of Veins, | 486 |
| Trional and Tetronal as Hypnotics and Sedatives for the Insane, | 442 |
| Tuberculous Pleurisy, | 515 |
| TULEY, HENRY E., M. D., | 146 |
| Tumors of the Neck. By W. L. Rodman, M. D., | 1 |
| Typhoid Fever: Its Importance. By J. Fulton Purdom, M. D., | 375 |
| Typhoid Fever, The Milk Supply as a Source of Infection in, | 283 |
| Urethral Growths: With a Case. By Thomas S. Bullock, M. D., | 263 |
| Vaginal Discharges, The Significance of, | 279 |
| WEIR, JAMES, JR., M. D., | 254 |
| What the General Practitioner Should Know about Diseases of the Eye. By Frank Trester Smith, A. M., M. D., | 455 |
| William F. Jenks Memorial Prize, The, | 167 |

THE AMERICAN PRACTITIONER AND NEWS

"*NEC TENUI PENNĀ.*"

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NO. I.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

PREVENTABLE FORMS OF DISEASE.*

BY JOHN FORD BARBOUR, M. A., M. D.

The four forms of disease to which I invite your attention this evening are typhoid fever, diphtheria, scarlet fever, and puerperal fever. These have been chosen for the reason that the first two, typhoid fever and diphtheria, rank next to consumption in our mortality statistics; and for the further reason that these, of all diseases known to us, are the ones most directly and certainly preventable by proper hygienic and sanitary precautions.

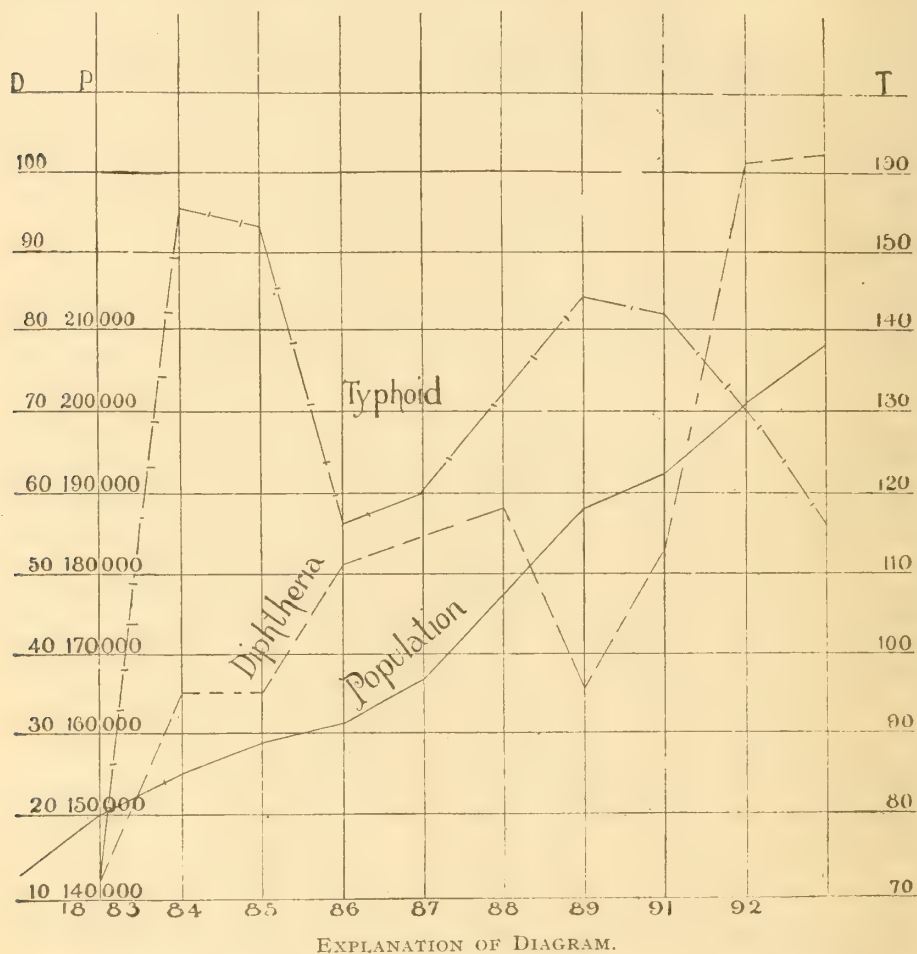
Typhoid fever, as every one of us knows, is produced by a specific micro-organism, the bacillus typhosus, which has been carefully studied by Koch, Eberth, Meyer, Friedlander, and Gaffky, and later by Frankel and Simmonds. These observers are agreed that these germs are discharged from the patient's body only in the excrement. This fact has been established both clinically and experimentally time and again, and is as certain as any thing in medicine. After their discharge they increase rapidly in numbers and in virulency. It has been noticed that those who wash the clothing and bed linen, a few days after they have been stained by the discharge, are in more danger of contracting the disease than the nurse who removes the bed pan from under the patient.

Germs enter the system mainly by way of the intestine, in the drinking-water, or polluted food, and also, in all probability, by inhalation.

Now it would seem to be as plain as the nose on a man's face that the way to prevent the spread of typhoid fever is to destroy the germs

*Read to the Jefferson County Medical Society.

at once as soon as they are voided by the patient; and yet in all this broad land, as far as I have been able to learn, there is no law or ordinance to prevent a man from throwing an infected typhoid stool into a privy-vault and infecting the water supply for an unknown distance around.



The figures running across the page represent the years; those under P, the population; those under D, the deaths from diphtheria; those under T, the deaths from typhoid fever. For instance, in 1884 the population was 155,000, the number of deaths from typhoid fever, 155, or 1-1,000; in 1891 the population was 201,000, the number of deaths from diphtheria, 101, or about 1-2,000. Only every tenth line of the original diagram is shown.

As every one who has paid any attention to the subject knows, the wells and privy-vaults in this city intercommunicate through the medium of the underground water. If any one should deliberately

throw a poisonous amount of arsenic into one of our public wells it would be regarded as a dastardly crime. Yet every day people empty into their privy-vaults typhoid stools which just as easily find their way into the wells as if they were emptied directly therein. Moreover, the typhoid-fever poison has the property of multiplying itself enormously, which arsenic has not. You have read, "Cast thy bread upon the waters; for thou shalt find it after many days;" but I say unto you, "Cast your typhoid stools into the privy-vaults, and after not not many days you shall hear from it in the West End."

Certainly our republican form of government is a conspicuous failure in some respects. In all matters pertaining to health the people should be legislated for as if they were children, as they really are in such matters. Under the paternal government of Germany such unsanitary conditions as prevail among us would not be tolerated for an instant. The indignant outcry that greeted the suggestion of the officer of the State Board of Health that the city was not clean only serves to show the natural result of the "*Vox populi, vox Dei*" doctrine. The right of private judgment does not extend to sanitary affairs. The citizens could hardly have been more indignant if Dr. McCormack had accused them of personal uncleanness.

I have prepared a diagram showing the relation of typhoid fever to the population. From this diagram you will see that there has been a very perceptible decline in the number of cases since 1889. This decline is due to the unmerited mercy of God, for there has been no attempt made in any way to prevent the spread of the disease. I learn from the City Engineer's office that only about one third of the city is sewered, and even in this portion nearly every house has a privy-vault. In other words, fully three fourths of the excrement of the city goes into the ground to poison it. It is safe to say that nine tenths of the plumbing is defective, since this matter is left entirely to the honesty and intelligence of the plumber. In the majority of cases the old-fashioned pan-closet is found.

George E. Waring, jr., one of our best sanitary engineers, has this to say of the pan-closet and the privy-vault:

A very large majority of the water-closets in use throughout the world are either very imperfectly flushed "hoppers" or that worst of all forms known as the "pan" closet, where a slight depth of water is held in the bowl by a hinged pan closing over its outlet. This pan swings in an iron chamber under the bowl, which is entirely cut off from ventilation, which

is generally foul with adhering fecal matter, and which as an abomination has no equal in the whole range of plumbing appliances. The closet of which it forms a part has every thing to condemn it, and only its cheapness and its apparent cleanliness and the habit of the world in its use to commend it. If flushed, as it usually is, by a valve on the supply pipe, it is rarely flushed adequately, and its use not seldom leads to an indraft of foul air (or worse) into the main water-supply system of the house. Such closets may be easily inspected as to their condition by shutting off their water supply, opening the pan, and lowering a candle into the container below. Such an inspection will almost invariably disclose an extremely and dangerously filthy condition.

Of the privy-vault he says:

They are always the seat of the foulest and even of the most dangerous decomposition. They taint not only the air and soil, but the water of the soil which goes so often to feed our sources of drinking-water, and their local stench is of itself sufficient to sicken all who have not, by daily and lifelong habit, become accustomed to it. It is not too much to say that the best sanitary service that can be rendered by those interested in the removal of causes of ill health would be in securing the abolition of these barbarous domestic appliances.

So long as such conditions as these prevail in Louisville, so long will typhoid fever continue to prevail, just as certainly as two and two make four.

The next disease I invite your attention to is diphtheria. Here the diagram tells a very different tale. It shows that except from 1888 to 1889 this disease has increased out of all proportion to the population, and that the increase since 1889 has been alarmingly rapid. This is not to be wondered at when we consider that there is practically no quarantine enforced against it.

In this disease the germ is found only in the false membrane. Of all germs known to us it seems the most tenacious of life. There are well-authenticated cases where it has lived for two years and even longer, and then produced the disease. This only serves to show what extreme care is necessary in disinfecting the apartment and clothing after an attack. This important duty should not be intrusted to the laity.

To give you an idea of what may be accomplished by proper care and disinfection, I quote to you from *Le Progrès Médical* the following: When Dr. Sevestre took charge of the diphtheria ward in the Foundling Hospital in Paris the disease was very prevalent. In the first semester of 1887 there were 62 cases, in the second semester 61. In the first

semester of 1888 there were 78 cases. He immediately enforced rigorous quarantine, disinfection and antiseptis, and reduced the number in the following semester to 13.

In the city of Havre the deaths from this cause ran: In 1881, 142; in 1882, 176; in 1883, 112; in 1884, 105. In 1885 sanitary precautions were adopted and fumigation with sulphur by a sanitary policeman enforced. By 1889 the number of deaths had fallen to 41.

The scarlet fever diagram does not show any definite relation between this disease and the curve of population; but as it sometimes assumes a very malignant form, and as even the mildest cases may be followed by severe sequelæ, it should be just as carefully guarded against as the other diseases.

The last affection I shall call your attention to is puerperal fever. This is one of the most preventable of all diseases. A great French physician made the remark, "When I see a woman dying of puerperal septicemia I say, 'there is a homicide.'" And yet I find in the mortality statistics of the city, since 1883, 151 deaths from this cause, and 341 from peritonitis, one half of which were probably puerperal, which would give a total of 321 deaths from uncleanly midwifery.

In Germany antiseptic midwifery is enforced by law. I read lately in a foreign journal where a midwife had been sentenced to three years and a half in the penitentiary for neglecting these precautions.

Statistics upon this subject leave no doubt whatever that child-bed fever is the result of criminal carelessness, and the laity should be made aware of the fact that where a woman dies of the disease it is the fault of her physician. Cleanliness in obstetrics should be enforced by heavy penalties, as is the case in Germany.

The cleansing of the hands prior to obstetrical and surgical operations is not so simple a matter as it might seem. Kummel has shown that cleansing the hands with the brush for five minutes with soap and warm water, and scrubbing with boiled water, never prevent the development of colonies of bacteria, and that what is needed is a thorough washing of the hands with the help of the brush for three minutes with warm soapsuds, then with carbolized water (five per cent) to destroy the microbe.

Jules Roux and Reyner have lately made some interesting experiments. After successive scrubblings they cleaned out, by means of a sterilized wire, the subungual space, and sowed the products on agar-agar. No washing or scrubbing of the hands with warm water or soap,

followed by carbolic water (ten per cent), prevented under these circumstances the development of micro-organisms. To accomplish this it was necessary to do as Fuerbringer recommends:

1. Dry-scrape the nails and the subungual space.
2. Wash and brush with hot soapsuds at least half a minute.
3. Wash and brush with alcohol at 80° for the same time.
4. Before the complete evaporation of the alcohol, make a final cleansing with the antiseptic solution, using again the nail-brush.

In order to learn what care was taken to prevent the spread of contagious disease in other cities, I entered into correspondence with the Health Officers, and learned the following facts:

In New York physicians are required (not advised) on being called to a case of contagious disease to go at once to the nearest telephone and communicate with the Health Office. The patient is removed without loss of time to the Willard Parker Hospital. In this way quarantine is established as early as possible.

In Cincinnati physicians are provided with postal cards, on which they are required to report all cases of contagious disease. As soon as this report is received a sanitary officer is sent to the house to obtain the names of all the children living in the house, and the schools they attend. A notice is then sent to each of the principals of these schools, and none of the children is allowed to return to school without a written permit from the Board of Health. The house is kept carded and quarantined for two weeks after the attending physician has ceased his visits.

Practically the same system prevails in Cleveland, in Indianapolis, and in nearly every city and even town in the North and West.

To show you how these matters are looked after in Louisville, I will read you the ordinances bearing on the subject from the Louisville City Code:

LOUISVILLE CITY CODE.

SECTION 10. The duties of the Board of Health shall be to watch over the sanitary condition of the city, to carefully guard against all causes of disease, to use all known measures to prevent introduction and spreading of contagious or infectious diseases, and to perform such other duties as time and experience may determine necessary to promote the health of the inhabitants of this city.

SECTION 13. When a proper complaint is made, or a reasonable belief exists that an infectious or contagious disease prevails in any locality or house, the Board of Health shall cause such locality or house to be visited by the Health Officer for the purpose of inspection, and when such infectious

or contagious disease is found to exist, the Health Officer is empowered to send the person or persons to the Eruptive Hospital or to such other place as may hereafter be provided for the reception of such persons. And in case any person so afflicted shall refuse to leave his house, it shall be the duty of the occupant of such house to warn the public of the existence of such disease by the display of a yellow flag from any portion of the premises designated by the Health Officer; such flag to be furnished by the Board of Health.

FINES AND MISDEMEANORS.

SECTION 21. Any person who shall knowingly introduce or aid in introducing into the city any contagious disease, or who, knowing any person to be laboring under such disease in the city, shall fail, within twelve hours, to inform the mayor or an officer of the Board of Health thereof, shall be fined \$50.

SECTION 59. No privy shall be built without a vault at least twelve nor more than thirty feet deep, and walled with hard brick; nor shall any part of the contents of any privy vault be removed except by its being taken out of the city or into the current of the river in the night-time. Each privy shall be kept in proper condition at all times, and from April 1st to last of October shall be well sprinkled with lime at least twice in each month.

In conclusion, gentlemen, when the health of the city of Louisville is brought up for discussion, it is customary to say that the death-rate is very low. But this is a very poor test of the sanitary condition of a place. The real test is the number of doctors it supports; and from this point of view Louisville is certainly in a very bad way.

LOUISVILLE.

CEREBRAL SYPHILIS.*

BY J. E. HAYS, M. D.

Demonstrator of Anatomy, Hospital Medical College, Louisville, Ky.

I have prepared this paper with the object of presenting to the Society in a condensed form the history of two cases of cerebral syphilis that have lately come under my care. An interesting feature of each case is the wide interval of apparent cure between the disappearance of the secondary manifestations and the beginning of the cerebral disturbance. As both cases were accompanied by paralysis which was hemiplegic in character, they forcibly illustrate the danger and serious effects that may possibly result from the products of a syphilitic dyscrasia.

*Read before the Louisville Medico-Chirurgical Society, December 9, 1892. For discussion, see p. 18.

CASE I. Mr. P., aged forty-six, an Englishman. I was called to this case February 1, 1892, and found him with complete paralysis of the left arm and leg; his power of speech was slightly impaired, and there was also some difficulty in swallowing. The attack had been sudden, and was not attended by any loss of consciousness. Prior to the loss of power on left side there had been no complaint of pain in the head, no vertigo, no staggering or uncertain gait; in fact no symptom that would indicate an approaching paralysis. His general health for many years previous to the attack had been excellent; his habits had been regular; he used nothing alcoholic nor tobacco in any form; his occupation was that of foreman in a large manufacturing establishment in this city.

A careful inquiry into the previous history for something that would throw light on the cause of the hemiplegia revealed the following: At the age of twenty-six he contracted syphilis. The primary sore was cauterized, and internal treatment, the nature of which he did not know, continuously administered for several months. Following the initial lesion had been some glandular enlargements, slight falling out of hair, but no eruption on the face or body. From the history it seemed to me that there could be very little doubt in regard to the nature of the lesion that had occasioned his paralysis, and he was at once given iodide of potassium in gradually increasing doses. For two months his improvement was very satisfactory; in this time he had sufficiently recovered the use of his leg to enable him to walk about, but his arm was still almost powerless. He looked, ate, and slept well. The amount of iodide of potassium had been increased to forty grains three times a day. A larger amount of the remedy was badly borne, and it was decided to continue this dose. On the 6th of April he developed a severe pleurisy on the left side; this was attributable to an exposure immediately after taking a Turkish bath. Dr. Bailey saw the case with me a few times during this attack. An effusion of moderate amount took place in the pleural sac, but disappeared under treatment in a few days. On April 20th pleurisy occurred on the right side; this was also attended by effusion, not as great, however, in amount as that had been on the left side. Shortly after the disappearance of this he was seized with a violent bronchitis which so closely simulated tubercular phthisis that for a while it was calculated to deceive, especially as the attack was attended by persistent cough, profuse yellowish expectoration, rapid loss of color and strength, night-sweats, and a fever somewhat

hectic in character. His treatment at this time was mainly the syrup of hydriotic acid, a generous allowance of port wine, and plenty of liquid food. Later he was also given the compound syrup of the hypophosphites. His improvement for several weeks was very slow; the chest symptoms did not entirely disappear until September. Since then, under the use of the iodides and faradism, he has made considerable progress toward regaining the use and strength of the paralyzed limb. A few weeks ago he resumed his work at the factory.

CASE 2. Mr. J., aged forty-two, carpenter. This is a somewhat similar case to the one just reported. I saw him shortly after the attack of hemiplegia, and elicited the following facts: Eighteen years ago he had an indurated sore on the penis; secondary manifestations followed, but were slight. He did not remember the duration of the treatment, but said that he continued to take medicine until the physician pronounced him cured. Since abandoning the treatment there had been no further outbreak on his skin. He married, and has a son living, aged fifteen, whose upper central incisors on examination showed the characteristic malformation of inherited syphilis, as described by Hutchinson. The patient's health, notwithstanding bad hygienic surroundings and habits, had remained in good general condition until last May. At this time symptoms of vertigo made their appearance, and soon became well marked and persistent. In walking he felt an almost continual tendency to pitch forward, and to the left side; his mind frequently became confused, and his memory was poor. On account of the dizziness he was compelled to quit his work. The physician to whom he applied for relief overlooking the true cause of the trouble, and thinking that the vertigo was stomachal in origin, advised him to quit the use of stimulants, to which he was somewhat addicted, live on a spare diet, and keep his bowels freely moved by the daily use of a laxative water, the Carlsbad preferred. This failed to give relief. On the 2d day of June left hemiplegia occurred, complete loss of motion, but no lessening of sensation of the arm and leg. There was no loss of consciousness, slight if any impairment of his intellectual powers; he could articulate distinctly, but talked slowly and with some effort. There was no diminution in the acuteness of his vision.

The history given by the patient having established such a clear connection between syphilis and his present condition, he was at once given large doses of iodide of potassium. This was increased until he

received as the maximum amount one hundred and eighty grains daily. In addition to this he has at intervals also received a small or "tonic" dose of the bichloride of mercury and Huxham's tincture of cinchona. His progress toward recovery has been rapid and uninterrupted; he has gained about twenty pounds in weight; feels well and can easily walk several squares without a cane. He has, however, regained but little use of the arm. He will probably never be able to resume his accustomed work.

The treatment of these cases presents no novelty. Clinical observation has long taught us that iodide of potassium is the sovereign remedy for bringing about an absorption of these products of syphilis. Its effect on gummata is well known and positive. While the mercurial preparations properly administered may aid, they do not approach in effectiveness the iodine compounds. Mercury, however, in the early stages of the disease has the supremacy. We very justly ascribe to it a direct and destroying effect on the virus of syphilis, whatever that virus may be. This being true, the opinion very generally prevails that it is only after a most careful, intelligent, and prolonged treatment by mercury that a physician can promise exemption from the later or so-called tertiary manifestations. In regard to a disease so grave in its possible results as syphilis this fact ought not to be forgotten.

LOUISVILLE.

TREATMENT OF SYPHILITIC ULCERS.—V. T. Svertchkoff (*Vratch*, No. 38, 1892) finds that inveterate or obstinate syphilitic ulcers of any kind are best treated as follows: The lesion should be thoroughly cleansed with a two-per-cent solution of hydrogen peroxide, then dried with absorbent cotton wool, and covered with a piece of wool soaked in a one to two mixture of carbolic acid and camphor. The dressing should be changed two or three times a day. In from three to five days the ulcer becomes cleaner and studded all over with abundant succulent granulations. After this it should be dressed twice daily, either with a one to four mixture of aristol and vaseline oil, or with a mixture of dermatol and vaseline in equal parts, the layer being covered with a piece of mercurial plaster twice as large as the ulcer. Rapid cicatrization ensues, the lesion healing soundly according to its size, in from fifteen to forty days from the commencement of the treatment. The author mentions that in his hands the campho-phenol mixture alone proved of great service in cases of simple ulcers, suppurating wounds, soft chancres, and chancroid buboes.—*British Medical Journal*.

Reports of Societies.

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.*

Stated Meeting, December 9, 1892, Dr. F. C. Simpson, President, in the chair.

Dr. D. T. Smith: This young man has been in excellent health since childhood, with the exception that he had spasms for a short time during infancy, which any child might have. These spasms never occurred after he was two years old. He had no other form of illness until he was fifteen years of age, when he had an attack of malarial fever, which lasted two weeks, and after that an attack of typhoid fever. Before the attack of typhoid fever he felt at one time an itching over the right orbit, and reaching up his hand to ascertain what it was, he felt a tumor about the size of a wine grape projecting. That tumor disappeared, then it came again, this time slightly larger than before, and immediately over the left orbit; disappearing and again appearing in his ear; then on his cheek; then on his lip; once inside of his mouth; two or three times on the back of his head, and when I first saw him, about four weeks ago, the tumor was disappearing under the right eye. These tumors are rather soft, except in the middle, where there is a little more resistance that you can feel. Four evenings ago he felt a twinge just over his right eye, and reaching up his hand felt the tumor coming there. I saw it the next morning, it had then spread some and was projecting probably twice as much as you see now. It comes and goes very quickly, he will simply feel a little itching; put his finger to the spot and the tumor is there. There is no sore upon his skin; however, there is one little place which does not change, probably a mole, seemingly a little thickening of the skin forming a small lump. He compares these tumors as they pass away to the condition as observed in this spot that does not change.

Dr. Wm. Cheatham: It looks to me more like urticaria than any thing else.

Dr. W. L. Rodman: How long do these so-called tumors remain out; that is, for what length of time can they be detected from external appearance?

*Stenographically reported by C. C. Mapes, Louisville.

Dr. Smith: Sometimes two or three days; at other times they will appear and disappear in a very short time. Probably the average time is about two days in one place.

Dr. A. M. Cartledge: It strikes me that it is a misnomer to call this condition a tumor. I do not think it can be properly classed as a tumor. When Dr. Smith first described it, I thought it was probably a blood extravasation. I have seen several cases of subcutaneous hemorrhage of the scalp which had some resemblance to this case. Since making examination, however, I think it is neurotic. The case more properly comes under nervous irritation, or a vaso-motor paresis.

Dr. A. M. Vance: I believe the trouble is urticaria; I do not see what else it can be; it looks and feels to me like urticaria.

Dr. Rodman: I am fully satisfied that these swellings are not tumors. The whole history of the case clearly excludes all possibility of tumors or neoplasms. No tumor could grow in so short a time, and disappear so rapidly. I take the view that Dr. Vance does, and am satisfied that it is a disease of the skin.

Dr. Smith: I agree in the main with what Dr. Cartledge said. He stated, I believe, that it is vaso-motor paresis. I think this enlargement is due to paralysis of the nerves controlling the capillaries and arterials, allowing an accumulation of fluid in them mostly blood. At first there is a little discoloration, and finally a very slight ecchymosis, the skin seeming to be involved to that extent. And yet this tumor has appeared once inside of the mouth. While the origin of the trouble is in the nerve control, yet I think it is remotely related to urticaria. Cases of this kind must be very rare, as there is so little record of them. I shall look further, and it may be that I shall find some reflex cause. There is no organic change in the brain, as shown by the migratory character of the tumor, and the trouble must be functional. The reflex may be in the stomach, but I have not been able to find it. I have not examined the nose; however, there has been no complaint. The patient has been in perfect health, and I have been unable to find the least trace of history of any other trouble. I must still denominate this a tumor, though, of course, I am aware it has nothing of the nature of a neoplasm.

Dr. Cartledge: I have two specimens to present, one of which I think is of special interest. A short time ago I saw in consultation a girl sixteen years of age, with the history that six months before there was observed in the right mammary gland a tumor the size of an ordinary

marble, about midway between the nipple and the axilla. Her physician, on account of the girl's age, kept her under observation for a while, but in the last month he noticed very rapid growth of this tumor, and also at the last examination, a week or ten days ago, he observed one enlarged gland in the axilla. He also observed at the last examination that the superficial veins over this tumor were very much enlarged. The girl complained of lancinating pain. As I said, she was only sixteen years of age, and apparently very robust in health. On examination a tumor the size of a goose-egg could be felt in the breast indicated, of a distinctly movable character; it seemed as if you could grasp it, and it could be moved separate from the gland substance proper, and slightly lobulated. Below this tumor was a distinct second nodulation, and a groove between the two. It seemed to correspond, as it took a more backward direction, to the lymphatic vessels going from the breast to the axillary space. At this examination I only felt one enlarged lymphatic gland in the axillary region. As to the question of diagnosis in this case, of course it would present some features of interest. Here we had a girl whose age was decidedly against malignant tumor of the mammary gland; with a clinical history of six months duration and pain; enlargement of the superficial blood-vessels and enlargement of the lymphatics in the axillary region. From the history of the case I had no hesitancy in pronouncing it sarcoma; it presented every evidence of malignant growth, and the age of the patient would exclude carcinoma. There was no history of trauma. Believing that all neoplasms of the breast, without exception, should be subjected to complete extirpation of the breast and cleaning out of the axillary space, I advised this and the operation was done three days ago. The entire breast was removed, and you will observe that the tumor is distinctly encapsulated, entirely separate from the breast substance itself. The glands removed were simply lymphatics. A thorough microscopic examination has not yet been made of the tumor. Certainly the growth as it appears since its removal more than ever bears out the opinion that was conceived of it beforehand, and it has every evidence of a sarcomatous growth. The tumor presents some appearance of a fibroma to look at it, but just beneath it we have this clear metastasis, with enlarged lymphatics showing the malignant character of it. The examination thus far has been a very rough one, the gentleman simply making a section without coloring it. He believed it would prove to be a interstitial mammitis of the breast, probably inflammatory. But

the encapsulated condition indicates clearly to me that it is a sarcomatous growth, or a fibroma that has undergone sarcomatous degeneration, which we know is so common in this location. It does not present many features of an adenoma, and even this should be subjected to the same treatment. The age of the patient is one of the most peculiar features. One gentleman who has written on this subject claims that the earliest case of sarcoma occurring in the female mammary glands is eighteen years. However, there has been one case reported in this city at the age of fourteen. I am certain that all such growths will be considered malignant by me from a clinical standpoint.

CASE 2. This specimen is of greater interest to the general practitioner than to surgeons. My attention was called to the case by visiting another patient in the same house. The lady said she had been a sufferer with dyspepsia for a long time, that she had to live principally on fluids, etc. I thought I recognized in her face the peculiar expression indicating ovarian disease. I made a careful examination and found a clear case of cyst of the ovary. Operation was performed to-day, tumor removed weighing between thirty and fifty pounds; there were no adhesions; patient bore the operation well; when she was taken off the table pulse was 80; she had no shock and nothing to indicate further trouble. This case is interesting from the fact that the woman had never complained of any thing except dyspepsia, and there was nothing to indicate presence of the cyst, except the enlargement which might have been due to other causes. The patient never suffered any severe pain or inconvenience from the presence of the tumor.

Dr. Rodman: I am compelled to agree with Dr. Cartledge in what he says concerning his first specimen. I am satisfied, from the appearance of the growth and its clinical history, there can be no doubt as to its malignancy, and, being satisfied of this, whether it be carcinoma or sarcoma, the proper procedure was complete removal. According to S. W. Gross, the youngest case in which carcinoma of the mammary gland has occurred was twenty-one years. This was in the practice of Henry. His statistics show the youngest case of sarcoma of the mammæ to have been fourteen years of age. One case has been reported to this Society where the patient was not even thirteen years old. I think there is no doubt about the specimen presented being a sarcoma, and the doctor did the proper operation, removing the entire breast and cleaning out the axilla. In reference to glandular enlargements in these cases, I would slightly disagree with Dr. Cartledge. While the rule is not to have

involvement of the axillary glands in sarcomata of the breast, still there are other exceptions besides the case under discussion. Gross reports several I know. We also know that according to Butlin sarcomas of glandular organs, especially the tonsil, testicle, and lymphatic glands, are more likely to be followed by enlargement of the lymphatic glands than even carcinoma in like situations. The old idea that sarcoma never causes glandular involvement must pass away.

Dr. Vance: I agree with what has already been said, and believe the condition of this tumor was such as to justify complete removal of the breast. I would like to put on record a case I saw this summer. A very intelligent lady, forty-five years of age, consulted me in regard to a tumor of the breast, which was hard and painful at the time. I gave the usual stereotyped opinion that all tumors of the breast in a woman over thirty ought to be removed, and advised immediate removal. Operation was refused, and I did not see the patient for about a month, when she again called upon me. I made a second examination of the tumor, and it was then about half the size it was at the first examination. I will say, however, on the occasion of her first visit to me I advised the removal of corsets, which she had probably been wearing tightly laced, as she was quite a fleshy woman. At the second examination, notwithstanding the fact that the tumor had considerably decreased in size, I still advised its removal. At that time she told me that she attributed the disappearance of the tumor to the influence of prayer. In another month she returned and the tumor had entirely disappeared; then she wanted me to make a statement that I had examined her on a certain date, finding cancer of the breast; had examined her on another date and found the cancer about half the size, and again on such and such a date when the tumor had totally disappeared. This is the first case in my experience where tumor of the breast has disappeared. Dr. Hays will remember another case where the tumor was not in the breast, but in the pectoral muscle, just anterior of the axillary space. In this case both Dr. Hays and myself thought it was a cancer, and advised early removal. This patient consulted some "faith doctor," and the tumor entirely disappeared.

Dr. W. O. Roberts: I am sorry I did not hear Dr. Cartledge's report of the tumor of the breast. Of course the younger the subject the more apt it is to be sarcoma. We find many cases of sarcoma of the breast that have gone on for some time, and others which have grown very rapidly with no glandular enlargement in the axilla. I remember one

case, not very long ago, where there was very rapid growth, so rapid that the physician in attendance took it to be an abscess of the breast, and lanced it, evacuating nothing but blood. I afterward removed the growth and found no enlargement of the glands of the axilla. The character of the growth of course influences to a great extent the enlargement of the glands. We have glandular enlargement nearly always in melanotic sarcoma which goes through the system, not only through the blood but through the lymphatics; we have this sometimes in other forms of sarcoma, but chiefly in the melanotic. In this connection I would like to refer to the case of melanotic tumor removed from the groin of a very fleshy woman, which I reported some time ago, Dr. Rodman assisting in the operation. Within the last month there has been a recurrence of the disease, there are several tumors on the body, but not at the point from which the original growth was removed.

Referring to what Dr. Cartledge has said about the ovarian cyst, I recently reported a case where I operated upon an old umbilical hernia, the patient being an exceedingly fleshy woman, and had not suspected ovarian tumor, nor had I, my attention having been directed to the irreducible umbilical hernia. During the operation for hernia the patient had a very severe vomiting spell, a great deal of the intestines protruding through the opening, and I detected a large ovarian tumor, which was promptly removed. My experience is that ovarian tumors are very frequently run across, just as in the case reported by Dr. Cartledge, by accident.

Dr. Smith: Dr. Douglas Morton used to insist upon a point in reference to removal of the glands in the axilla that seems to me entitled to much weight; that is, the danger of recurrence in the axilla was so limited that it did not justify removal of the glands. I notice most leading surgeons, however, are still urging the course recommended by Dr. Cartledge, the removal of all the glands of the axilla at the time the breast is removed, making a complete operation. If it is true that in only three per cent of the cases cancer returns in the axilla, then it does seem to me that the condition hardly warrants such a complete operation. I saw some time ago a report by Bigelow, I think, of Boston, where he had collected all the cases of cancer of the breast he could find, and only three per cent of them had recurred in the axilla, all the rest recurring in the scar. In view of this I think the complete removal of the axillary glands in all cases to prevent recurrence in so

small a percentage is hardly justifiable. I would like to know if any of the members present have any statistics on the subject.

Dr. Rodman: The best results which have been obtained in the operative treatment of malignant disease of the breast is by a free incision, removing all the glands, and also invading the axilla and removing all enlarged glands and other suspicious tissue. This done, we get results second only to operations for the removal of the carcinoma of the lip. Dennis' statistics, made from a large number of cases of malignant disease of the breast treated by free incision, are so good as to approximate in results operations for epithelioma of the lip, the best in the whole field of operative surgery for malignant disease.

Dr. Vance: In operations of this character at the Johns Hopkins Hospital I observed, while there recently, that they not only cleaned out all lymphatic glands of the axilla, but also removed all the pectoral muscle on the side affected. Dr. Halstead claims that this is the only way you can hope to entirely remove the cancer. I believe that the wider you go the better it will be.

Dr. Cartledge: I have very little to say in closing: One point in regard to lymphatic enlargements in sarcoma, carcinoma, and other tumors of the breast, there is something in what Dr. Smith says in that it gives a suggestion as to the causation of lymphatic enlargements in growths of the mammary glands. I am a firm believer that originally and primarily many and very much of the lymphatic enlargement of the axilla is inflammatory in character from the absorption of pyogenic micro-organisms rather than from metastasis.

In regard to cleaning out the axilla: I think the best way to prove to Dr. Smith that this should be done is that twenty-five years ago the percentage of recurrence in removal of cancers of the breast was so great that many of the best surgeons advised against the operation. Later they removed the cancer and the lymphatic glands, and their percentage of recoveries was a little better; then they went wider and removed the cancer, the breast, and the lymphatics, and the percentage of recoveries was still greater. Now they go still further than this and remove the pectoral muscles, and the results are more satisfactory. I believe that the more structures you remove, within reason, the better the result will be.

Dr. Smith: It still seems to me hardly necessary or justifiable to remove the pectoral muscles and lymphatic glands in these cases, considering the percentage of recurrence in the axillary region. In the

older operations spoken of by Dr. Cartledge, I am forced to believe that if there had been more complete removal of the cancer itself, the percentage of recurrence would have been much less.

Dr. Cartledge: If you remove a cancer of the breast ever so thoroughly and then slit up the enlarged lymphatic glands and submit to a microscopical examination, usually cancerous elements will be found there.

Dr. J. E. Hays read an essay on Cerebral Syphilis. [See page 7.]

DISCUSSION.

Dr. Vance: I only want to say one thing that has been brought up by the paper. My experience proves to me the importance of mercurial treatment in these cases just as much as in the primary stage. I believe that a patient suffering from syphilitic trouble must take about so much mercury before he can be entirely relieved. Though iodide of potassium might bring about the same results, it is a question whether such results would be permanent. While we all know the good effects of iodide of potassium in these cases, it is my opinion that if mercury were given in proper doses from the beginning of the first symptoms the results would be better and more permanent.

Dr. Cartledge: I would like to ask Dr. Hays how much mercury he would advise in these cases, and the dose given in the cases referred to.

Dr. J. E. Hays: I believe the dose has to be regulated as to quantity by each individual case. I gave in the two cases reported one fiftieth of a grain.

Dr. C. W. Kelly: I have never given mercury in any stage of syphilis; I much prefer iodide of potassium, and believe this will produce much more satisfactory and more certain results.

Dr. Roberts: I think in these cases we should push iodide of potassium to the extent that the patient is able to bear it. I had a case of brain syphilis some time ago, with Dr. Bodine, in which we steadily increased the quantity of iodide until the patient took one and one half ounces per day—one half ounce at a dose three times a day. This quantity produced no trouble in the alimentary tract, but he had most excessive diuresis, passing enormous quantities of water during the time he was taking these large doses of iodide. It was given largely diluted. This treatment cleared up the brain entirely; the man is now seemingly in perfect health; has since married and has two children.

Dr. Cheatham: It is my practice to treat syphilis in either the first,

second or third stage with a combination of iodide of potassium and mercury. I believe that in brain syphilis mercury given by inunction will produce better results than when given by the stomach.

Dr. Cartledge: I am satisfied in my own mind that while we all have about the same things to use in the treatment of syphilis in the various stages, first, second or third, the remedies, mercury and iodide of potassium being the chief, the manner in which we use them has a great deal to do with whether we have success or failure. In those cases where we have deposits pressing upon delicate structures, where it is desirable to remove them very quickly, such as the cases referred to by the essayist, I believe that we get the most rapid results by confining ourselves to the one remedy, iodide of potassium. I think mercury is a valuable agent in syphilis, but there is a difference in the action of these two agents. One point that I desire to call especial attention to is this, that at the same time we are administering iodide of potassium we should also establish systemic drainage; this can be accomplished by two-grain doses of calomel. I also think quinine may be given in these cases with a great deal of benefit.

Dr. S. G. Dabney: I see a good many cases of syphilis in the tertiary stage, and occasionally meet with the secondary form in diseases of the eye, nose, and throat, less often in the ear. In these cases I have used mixed treatment with good results. I will mention as a fact of some interest a case of syphilis I saw recently in which there was paralysis of one of the muscles of the eye within four months after the first inoculation. The ocular paralysis developed earlier and more rapidly in this case than it usually does. Disorders of the ocular muscles and of the pupils are common symptoms in brain syphilis, but as they did not occur in the cases reported by Dr. Hays it would probably not be in place to discuss them here.

Dr. Smith: In my experience I have only seen one case of brain syphilis; this patient was about thirty-six years of age, a carpenter by trade. Diagnosis was made of cerebral syphilis, which was first noticed by his staggering walk. I had him under observation for nearly three years, and think there could have been no doubt as to the diagnosis. He was given large doses of iodide of potassium, probably up to twenty grains three times a day. I also pushed corrosive sublimate up to one sixteenth of a grain. He went back to his work under my treatment. He fell from a house at one time, being pretty badly crippled, which may have had something to do with aggravating the trouble. After

that he grew better, then worse, and finally became insane and was sent to the asylum, where he died. I believe in these cases of cerebral trouble we may very often be mistaken in the diagnosis as to whether there is syphilitic lesion or not.

Dr. C. Skinner: In treating syphilitic cases I give mercury preference by inunction in the second stage, iodide of potassium in the third, and nothing in the first. My reason for giving nothing in the first is to be positive about the diagnosis. I use mercury in the second stage by inunction, which I think is the best way to give it, keeping the bowels open, and saves the stomach. In the third stage I give large doses of iodide of potassium, gradually increasing. I will mention a case of cerebral syphilis in which a man failed to carry out directions, which is just in line with Dr. Hays' paper. I treated this man's wife in an abortion. Some time afterward I attended her in a second abortion; then she came to me in her third pregnancy and wanted me to bring about an abortion to avoid carrying the child to full term. Of course I told her I could not do this, but would try and tide her over the critical period. I put her on treatment with bichloride of mercury in one thirtieth-grain doses three times per day throughout the whole period of gestation. She then left the city. Returning some time afterward she again became pregnant, and I treated her in the same way through that period of gestation; a perfectly healthy child was born, and now shows no signs whatever of syphilis. The child is now five years old. I give the history of the man: At that time he gave me the history of having contracted syphilis twenty years before, which had apparently been cured, no further symptoms having developed until about two and one half years ago, when he showed signs of syphilis in his walk, loss of memory, etc. He said he could not remember any thing. I recognized what I thought to be a manifestation of return of the trouble, and put him on iodide of potassium. He improved very rapidly at first, so much so that he discontinued the use of iodide, and passed out of my notice for a while. Finally he came back to me with a return of the trouble, and I again gave him iodide of potassium, gradually increasing the dose. He again improved, and left off the medicine entirely. I was hurriedly called to his house some time afterward, and found the man in convulsions. He died in about four or five hours. His wife told me that he had not been taking medicine of any kind for about six months. I have since learned that he discontinued the use of iodide on the statement of the druggist from whom he purchased the drug, that he was

consuming a dangerous quantity (I think he was taking about four drams three times per day), and if he did not quit it would kill him.

Dr. J. M. Ray: I have seen a large number of cases of ulceration of the mucous membrane of the upper respiratory passages from syphilis, and must say that I believe iodide of potassium does more good than any thing else. It has been my practice to give mercury and iodide separately in these cases. I give iodide for an express purpose, and continue giving it until the desired results are obtained; until the ulcerated surfaces heal up. I continue the iodide as long as I have any local lesion present, then give mercury. I will make here a brief report of an interesting case I saw some time ago. It was a case of syphilis in which there was ulceration of the mucous membrane of the nose, with sloughing of the turbinated, and at the same time a chancre on the penis.

Dr. Hays: I have had only a few cases of the kind, I believe two in addition to the ones reported, since I have been practicing medicine, and I have never given mercury a trial in any tertiary lesion, excepting in the last case referred to in the paper. I must say, however, that iodide of potassium has never failed in a single instance. I believe this is the best known remedy in removing syphilitic infiltrations. I simply gave mercury in this case as an experiment, not having very much faith in its efficiency. I believe, like some authorities, that if mercury would destroy the germ of syphilis, if given early we could do away with all these latter manifestations, that is, the so-called tertiary symptoms.

J. E. HAYS, M. D., *Secretary.*

LOUISVILLE SURGICAL SOCIETY.*

Stated Meeting, November 14, 1892, Dr. A. M. Cartledge, President, in the chair.

Dr. W. C. Dugan: This little patient has a pronounced stricture of the esophagus, the result of swallowing a caustic. The stricture at first was impermeable, and in order to save the patient's life gastrostomy was performed last February at the Children's Hospital. The question I want to ask is whether it would be advisable now to close the opening in the stomach. A bougie about the size of your finger can easily be passed through the stricture, and the child is able to swallow all its food

*Stenographically reported by C. C. Mapes.

in the natural way. When the operation of gastrostomy was performed the patient was very thin, and absolutely unable to take any nourishment at all. You will see from his appearance to-night that he has gained in flesh by being fed through the tube, and as he is now able to swallow with little difficulty I am in favor of closing the opening. The wound gives him a great deal of trouble from irritation, there is some leakage, and the opening sometimes becomes prolapsed.

Dr. A. M. Cartledge: How often did you dilate the esophagus with the bougie?

Dr. Dugan: Every three or four days.

Dr. A. M. Vance: I am inclined to the opinion that the time has come when this wound should be closed. I do not see any reason now for keeping it open, as the patient is able to take nourishment into the stomach in the natural way.

Dr. W. L. Rodman: I think there are two sides to this case. While I am inclined to agree with Dr. Vance that this fistula should be closed, yet I think when the child begins to swallow hard substances the stricture is likely to close again, and it may then become necessary to re-open the gastric wound. This has been proven in my experience recently with a similar case at the City Hospital.

Dr. I. N. Bloom: I would like to ask Dr. Dugan to give some idea of how he would treat the case after closure of the fistula, the frequency with which he would use the bougie, and the probable result.

Dr. Wm. Cheatham: Intubation is often used in these cases. I have a set of tubes for this purpose. They can be worn permanently.

Dr. Dugan (in answer to Dr. Bloom): I propose to dilate the esophagus every week until Dr. Cheatham takes charge of the case and uses his tubes.

In regard to closing this fistula, I hardly know what would be the best method. I am rather inclined to think the best procedure would be to do a plastic operation, making an incision a little lower down and tearing the stomach loose entirely; that is, separate the mucous membrane and put in a puckering string.

Dr. Cartledge: I differ with Dr. Dugan as to the manner of closing this fistula. I do not see the necessity for separating the stomach nor making another incision. I think a good result could be obtained by simply paring the edges and using Thiersch solution. I believe the fistula ought to be closed, as the stricture has been dilated to such

extent that I think it will be the cause of no further trouble, for the present at least.

Dr. Dugan: I have two pathological specimens removed from the same patient, a pyosalpinx with abscess, and one ovary. The patient was twenty-six years of age, and four years ago had her first attack of pelvic trouble, which was diagnosticated as "ovarian neuralgia," and she was treated for that trouble. In a few months she had another attack, and so on, this being the fourth. At the time of the operation she was suffering from acute peritonitis, and in the midst of her menstrual period. From the fact that the peritonitis seemed to be becoming more and more general, operation was performed without delay. The uterus was prolapsed in Douglas' pouch, almost including the vagina, forcing the wall down; the adhesions were very dense and extensive, and this is the point I wish to call especial attention to. The patient has made a rapid recovery without an untoward symptom. No drainage was used.

Dr. Vance: I assisted in this operation, and I certainly never saw adhesions so dense, considering the size of the growth. We had to enlarge the original incision before it could be brought up at all. I congratulate Dr. Dugan upon the excellent result.

Dr. Dugan: This patient was taking three to four grains of morphine daily up to the time she was operated upon; it has not been necessary to give any since.

Dr. Vance: About a year ago Dr. McIntyre, of New Albany, Ind., brought a patient to me, forty-five years of age, who had for several years had a fistula over the left side of the pubic bone just on the outside of the external abdominal ring. At that time I could find nothing with the probe, and advised operation as the only means of curing it. This was declined, and I did not see the patient again until day before yesterday. The man came back and said he had tried a year's treatment with no benefit, and desired an operation performed. Without probing or looking at it I had him sent to the Infirmary, and after opening the sinus removed this little piece of bone, evidently one end of the pubic bone. It was perfectly loose and sequestered; it was near the surface, entirely detached, and lying crosswise of the opening. It is rather uncommon for the pubic bone to become necrosed; there is no history of injury or syphilis. The sinus was open to the detached piece of bone, and had been running for four or five years.

Dr. Cartledge: Necrosis in this region is extremely rare.

Dr. Turner Anderson: This is the second case of the kind I have seen. The first was a young lady I attended, who had osteitis affecting the symphysis. She was very promptly relieved by operation and scraping.

Dr. Cheatham read a paper on the most recent treatment of disease of the mastoid and brain abscess, the result of disease of the middle ear, and reported several cases: One, a young man who came to him with acute suppuration of both middle ears, July 28, 1892, has vertigo. I put him on appropriate treatment. August 1st: He reported, with increased vertigo and great tumefaction of tissues over mastoid and tissues of right side of neck; great pain over right side of head. August 11th: Vertigo increased; neuritis, right optic nerve; tumefaction over mastoid and of neck nearly gone; nystagmus. Temperature, 99.2°. August 13th: Temperature normal. Says he feels like a two-year-old. Vertigo much less. August 15th: Pain in left ear. August 18th: Slight edema over left mastoid; pain down side of neck and into shoulder. August 21st: Vertigo so great some one has to hold him up; pain left side of neck increasing; neuritis, both optic nerves; auditory canal much swollen; left middle ear full of granulations. Middle ear curetted, and a large mass of granulation tissue removed. August 22d: Pulse, 60; temperature, 99°; sleeps most of the time; talks well when aroused; ocular conjunctiva congested, and very dry; cornea very dry; pulse, 60; temperature, 99.5°; pupils dilated; will not take nourishment; some loss of grip in right hand. Has complained for several days of great pain over left side of head; slight rigors. Dr. Dugan called to see him. It is now more difficult to arouse him. Some effort required to fix his attention, and he does not recognize people well. An operation decided upon. Tumefaction of left side of neck very great, with great tenderness at apex of mastoid and along the jugular vein. I drilled into both mastoids, but found no pus. Dr. Dugan will give an account of his part of the operation.

Since the operation the patient has made an uninterrupted recovery, except a slight vertigo and deafness of left ear. No pain; no optic neuritis; vision perfect; inclined to fall to the left. The scalp wound healed readily. There was no hernia of the brain when opened. He recovered consciousness very quickly after the operation.

This case looked to me like one of pyemic thrombus of the lateral sinus. Mr. Chas. A. Ballance, of London, reports four cases of pyemic thrombi of the lateral sinus, in which he tied the internal jugular vein and curetted the sinus, with two recoveries.

Dr. Dugan: The operation spoken of by Dr. Cheatham in his paper was done by the chisel. I used a chisel with a curved cutting edge and a mallet instead of the trephine. I like it much better than the trephine, and you can cut down upon the lateral sinus, exposing it without danger of doing any damage. After having exposed the lateral sinus and finding no pus, with a hypodermic needle we also explored the cerebrum and cerebellum, going very deep in the tissues, but were unable to find any thing at all. If we had found in the lateral sinus a thrombus, we would then have removed that, carefully dissecting out as far as the thrombus went; but finding no thrombus we stopped. I was very much surprised to find no evidences of brain trouble whatever in this case. This is the second case I have operated upon recently with the chisel, and am very much pleased with it. In regard to hemorrhage, if you should open the lateral sinus there is absolutely no danger. When operating on these cases we should always have a tampon of gauze ready, so that when you get it open it can be tamponed at once. If proper attention is paid to asepsis during the progress of the work there will be no danger from septic trouble. You can cut down and perform an operation on the jugular, using the tampon, with as much success as the lateral sinus.

Dr. Cartledge: How much brain in this case did you expose?

Dr. Dugan: A space about the size of a silver dollar.

Dr. H. H. Grant: Did you make any cut through the bone before applying the chisel?

Dr. Dugan: No. I think in craniectomy the chisel can certainly be used to good advantage. I have a patient now that I am going to operate on, and intend to use the chisel instead of the trephine. If the chisel is held at an angle of fifteen to twenty degrees there is no danger at all; no danger of doing damage to the meninges.

Dr. Cartledge: In this connection I would state that the chisel is attracting considerable attention as a means of gaining access to the brain. I have never used it, but it does seem to me that the chisel can hardly take the place of the trephine in all cases; it might be used to advantage in removing a section of bone between the trephine holes; I have used it in this way for years. To gain access to the brain I do not see any advantages in the chisel, and it seems to me there are disadvantages. In the first place I do not see why there is less danger of wounding the meninges. I think there is danger of injury to the dura in using the trephine, and I believe there would be more danger in a

slanting chisel and a mallet. The matter of sawdust is of no particular consequence, as it can be easily washed away. In order to get a smooth, uniform opening, curetting is necessary by a chisel or Rongeur forceps. I have not used the chisel, as mentioned by Dr. Dugan, to take the place of the trephine, and must say I fail to see the especial advantage.

Dr. Grant: What width of chisel do you use?

Dr. Dugan: About a half-inch.

Dr. Cartledge: I think that in fully one half of the cases which demand the use of the trephine will be found one very common condition—that is, fracture of the inner table without fracture of the outer table. We all know how common it is, in using the trephine, to find an extensive fracture of the inner table with only a slight fracture or possibly no fracture of the outer table. I do not think there is any danger in using the trephine in these cases, but it seems to me that with the chisel there is danger of producing trauma to the brain. I do not see how the chisel can ever advantageously take the place of the trephine in such cases.

Dr. Vance: Do you think it advisable to use the trephine over the seat of pressure, or rather on one side?

Dr. Cartledge: You can never tell how much of the inner table is fractured until you cut down; of course the trephine pin should be set on sound bone.

Dr. Wm. Vissman (visiting): The chisel is used altogether in Germany; they never think of using the trephine. Chisels vary in width from three quarters down to a little over one quarter of an inch. By using the chisel and chipping off the bone little at a time you can feel, in fact you can see your way. The chisel is kept very sharp, and in cases of depression by setting it at a very acute angle, as stated by Dr. Dugan, you can find this depression, and then, if you should happen to slightly wound the brain, it is not going to do any great damage.

Dr. Dugan: In cases where you have a depression of the inner table the chisel should be set at a very acute angle and the bone chipped off a little at a time until you entirely remove the external table, and then you have the internal table exposed. In other words, you have removed the external table without coming in contact with the internal table at all. I operated a few days ago with the chisel, and had excellent results. It can be used with as great a degree of delicacy as any instrument, cutting just where you wish to within a hundredth part of an inch.

Dr. Vance: I saw a patient some time ago at La Grange, a young man thirty-two years of age, who had stricture of the urethra, and had been treated in Louisville by forcing a sound, which was very large, evidently a false passage being produced, resulting in a perineal abscess, which had been opened prior to my seeing him. I found an impermeable condition of the perineal stricture and a discharging sinus. I had a very short time between trains, and did an external urethrotomy, of course without a guide, and under great difficulties. The patient never was sufficiently under the influence of chloroform to get him in the proper position. A very large quantity of urine and pus was evacuated; the bladder was very much distended. I put in drainage and left the patient in charge of his physician. Six weeks afterward I went back to open up the anterior stricture, and found it absolutely impossible to get any thing through the anterior opening by the meatus. Under cocaine I worked some time with a small filiform, but failed; then introduced a tenotome through the perineal opening, and by this method the stricture was cut and I finally got in through the anterior urethra. The man made a very excellent recovery. One thing in the case that puzzled me very much was, after I had gotten the stricture relieved completely I could not get any thing through the anterior portion of the urethra. There seemed to be a surplus of mucous membrane in the urethra that interfered with the introduction of the sound after I had put a large catheter through from behind. I never met with a case that seemed to have such a quantity of mucous membrane in the urethra.

Dr. Dugan: I have operated several times recently without a guide with excellent success. I think if Dr. Vance had used a straight instrument instead of a curved one he would not have had so much trouble.

Dr. Vance: At the first operation we were able to get a very fine filiform through, but could not get any thing to go over it.

Dr. Dugan: I have a case that has puzzled me a great deal, and it has also puzzled several others. The patient is a young woman upon whom a laparotomy was performed some time ago. The trouble seems to have been originally retroverted uterus. Shortly after marriage she developed considerable pelvic trouble, was under treatment for a while, and was finally operated upon and a cyst of the broad ligament removed. The ovaries and tubes at the time seemed to be in a normal condition, and consequently were not removed. She does not seem to have improved very much from the operation, and for the last four or

five months has been growing gradually worse. Retroversion is so complete that it can be easily detected through the vagina, and she is now on the eve of another laparotomy in order to break up the adhesions and remove the tubes. She has intense pain all the time. Day before yesterday she had some rectal trouble, and it occurred to me it might be one of those reflex cases which would be promptly relieved by a simple operation. I introduced my finger into the rectum, and the outlines of the uterus could be easily felt in Douglas' pouch, the ovary and tube on the left side pressed down upon the vaginal walls. I think the case is a perfectly clear one of pus-tube of long standing. She has what is called "flushes," the skin becoming as red as the flush of scarlet fever. At this time her pulse is very rapid, running as high as 150 per minute, and hardly perceptible, and really at times she is perfectly wild.

Dr. Cartledge: Are the ovaries and tubes enlarged?

Dr. Dugan: The tube on the left side is as large as your forefinger. The uterus is retroverted, and the tube seems to rest on the lower part of the uterus between it and the vagina.

Dr. Cartledge: I believe that Dr. Dugan will find that while this tube and ovary are considerably enlarged, it is probably the result of interference of the circulation. Operation is clearly indicated, and I think the patient would be greatly benefited.

Dr. J. M. Mathews: Several years ago there was what was purported to be an anatomical discovery, as you all know, by a sect or by some professional brothers who do not agree with our way of thinking: they discovered the so-called "pockets" or "papillæ" of the rectum. Now, I would not occupy your time speaking of this matter except that it has become a very serious one. The gentleman that pretended to have made this discovery has written a work, and also gotten up a set of instruments which are used from one ocean to the other, and which aid in putting the practice extensively into use. The practice is, or was, I should say, the cutting out of the so-called pockets or papillæ of the rectum; you will understand, not for disease of the rectum only, but for any ailment that might affect the body. I know of one little child that was subjected to this treatment for asthma. I know of a gentleman who had his rectum, or a portion of it, excised for phthisis. I simply mention these two cases, but I could cite many others to prove how barbarous and how ridiculous the practice is. It is a surgical operation which any one will see at a moment's glance is capable of doing

a great deal of harm. For a good while they confined themselves to simply cutting out the pockets or papillæ, but now it seems they go further than this and excise a portion of the gut. Dr. Andrews, of Chicago, a very distinguished surgeon, was made aware of this fact, and to him we are indebted for exposure of the treatment. He submitted the matter to a number of anatomists, among them the eminent teacher, Dr. Smith, as to whether these structures were abnormal or normal, each of whom stated that they were normal structures of the rectum, intended to assist in lubricating the feces. I submitted the same thing to anatomists of this city, Drs. Kelly, Bodine, and Dugan, and each one of them agreed with Dr. Smith that they were normal structures. Therefore these men were cutting out structures natural to the parts for any disease that a person might be suffering from, claiming that by some strange procedure they either produced the disease, or, if they did not produce it, the disease would be greatly benefited by taking out these structures. As I say, for a time they contented themselves with the cutting out of these "pockets," and at one time I wrote an article calling the attention of the State Society to the fact that I had seen hemorrhage result, inflammation or proctitis excited, and that I had observed stricture of the gut as a sequence of such treatment. Now they go further than formerly, and resect a portion of the gut, as much as an inch of the lower rectum, and it is becoming so pronounced a thing that the profession of the United States are becoming aware of it, and are beginning to inquire about it. In this city the operation is being done rather extensively, and, being in this line, I hear of these cases and often see them after such treatment. As I have already stated, I have seen more than one stricture result from this practice. I have had several cases of ulceration of the gut resulting from the treatment. I would like to ask if the members of this Society have heard any thing about this wonderful (?) operation, or have met with any of the cases that have been subjected to this very unsurgical treatment. If it was not a serious matter, it would be ludicrous and could scarcely be believed. I have in my possession a number of letters from physicians telling me of the bad results of this practice.

Dr. Vance: I happen to know a patient now, a young man who consulted me on account of some trouble with his feet. Upon getting the history of the case I found he had a recent attack of gonorrhea, and evidently was suffering from gonorrheal rheumatism in a very aggravated form. I gave him a very blue prognosis as to the future progress

of the trouble; I ordered potassium iodide and rest. This man was able to take very large doses of iodide of potassium with very little relief. He finally consulted a homeopathic surgeon, who told him that his experience was that when a man was enabled to take such large doses of medicine without any effects there was some trouble with the outlets of his body, either the urethra or rectum. He made an examination, and found something wrong (?) with the rectum, and excised a portion of it to cure gonorrheal rheumatism. I have heard of a good many cases which have been operated upon by men who have been educated by the party in Chicago.

Dr. Dugan: Not many weeks ago a regular physician went from this city to Shelbyville, Kentucky, with the gentlemen referred to by Drs. Mathews and Vance, to assist in an operation. About an inch of the lower rectum was excised, and the gut brought down and stitched to the skin. I remember another patient who finally fell into my hands. The same man had treated him a long time for rheumatism, and failing to relieve him concluded there was some trouble with the alimentary canal, and performed an operation, removing several pockets from his rectum.

Dr. James S. Chenowith: I can add one more case. A young lady, eighteen years of age, was operated upon in the manner indicated for an aggravated case of hysteria.

Dr. Vance: I would like to mention a case I operated upon five weeks ago: a case of complete infantile paralysis of both lower extremities, a little boy nine years old, very small for his age. In the latter part of May last I excised his right knee at the Sts. Mary and Elizabeth Hospital, put the limb up in plaster of Paris dressing with a spica bandage. The first dressing was removed in five weeks. When it was taken off the wound was healed absolutely, leaving a mere line without any evidence of suppuration. I will state that the operation is by a transverse incision about the lower part of the patella, removing the patella and taking off the cartilages of both the tibia and femur and putting them together without any wire or any suture, the plaster dressing serving to keep the bones in apposition. Five weeks ago I excised the second knee and dressed it in the same way. The dressings were removed yesterday, and union had taken place without any trouble whatever. I will state that in the last operation no antiseptics were used, not even iodoform. I put one limb in slight flexion, and the other in hyper-extension, thereby hoping that he would be able to bal-

ance himself better. I think this will give better results than if both were perfectly straight, both flexed or both in hyper-extension. This is the first time I have performed double excision of the knee where recovery has taken place.

Dr. Dugan: I think Dr. Vance's idea of putting one leg in hyper-extension and the other in slight flexion is a very good one.

JAMES S. CHENOWITH, M. D., *Secretary.*

Foreign Correspondence.

LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

Dangers of Filters; Cholera Precaution; Inunction of Calomel; Precaution Necessary in Using Chlorate of Potash; Discontent in the Indian Medical Department; A Case of Hepatic Abscess; Treatment of Ringworm; Sad Suicide; The Horrors of Alkali Works, etc.

In the course of his evidence before the committee appointed by the Shipping Federation and the Chamber of Shipping to inquire as to the supply of food to sailors in the merchant service, Dr. Saunders said a filter usually became a greater evil than the one it was intended to remedy, because, unless it were cleaned very frequently and the filtering mediums were of a proper character, the water was absolutely filtered through sewage. If it were considered desirable to introduce filters, they ought to be mechanical filters with the water passing through disks of cloth under very great pressure, but the ordinary house filter was one of the greatest curses ever inflicted upon suffering humanity.

The Lord Mayor has presided at the Mansion House over a conference of Port Medical Officers of Health to consider the precautions necessary to prevent cholera in 1893. The Lord Mayor stated that the object of the meeting was to enable the delegates to carry out their duties intelligently and in a uniform manner, but he hoped that medical officers would not exercise their functions with unnecessary severity. At the suggestion of Dr. Armstrong, of Newcastle, it was agreed that it was desirable that medical inspection for the prevention of cholera should be kept up day and night without intermission. Several delegates spoke of the difficulty of inspection by night owing to the size of the docks; but Dr. Armstrong, in reply, while admitting that in some places it might not be practicable,

pointed out that they were being asked to vote on a general principle. It was also resolved, on the motion of the Hull Medical Officers, that it would be desirable for port sanitary authorities to approach the Local Government Board with a view of obtaining compulsory powers to detain all vessels from infected ports until a certificate of health had been given by the medical officer of health.

At the Lock Hospital one hundred and eighty cases of syphilis have been treated with calomel inunctions. The ointment is made thus: R Sublimated calomel, 5 to 10 parts; lanolin, 30 parts; cocoa butter, 100 parts. The inunctions are made precisely as in the case of gray ointment, each lasting for twenty to twenty-five minutes. Different areas of the body are selected from day to day, so that an interval of five to seven days shall elapse between two rubbings in the same locality. In the treatment five to seven rubbings were given; there being an interval of two or more weeks, during which iodide of potassium is administered internally from eight to twenty-five grains a day; then another interval is allowed and the inunctions are resumed—the whole treatment lasting for five or six weeks. It is found that cachectic and anemic patients can not be put under the inunction process until they have undergone a strong tonic treatment. The treatment so far has been fairly efficient.

In reviewing a recent medical work the *Therapeutic Gazette* makes the following remarks on chlorate of potash: "We are sorry that the author persists in statements with regard to the value of chlorate of potash in placental disease with decrease of the respiratory functions of the organ. It has already been proved again and again that chlorate of potash is absolutely valueless under such circumstances, and not only has clinical experience proved this to be true, but it is a physical impossibility for the chlorate to part with its oxygen in any quantity at the temperature of the body. If it exerts any effect whatever, it decreases the oxidizing powers of the blood through its action upon the hemoglobin, and there is great danger of irritating the kidneys." It may be remembered that Dr. Jacobi many years ago proved that chlorate of potash given in diphtheria, etc., produced nephritis. Until then most practitioners used to look upon this salt as quite a harmless substance. At the present time it is well known that the greatest precautions are necessary in prescribing it.

For some time past it has been more and more evident that the medical officers in the Indian Army are thoroughly dissatisfied with their lot. Every thing points to the conclusion that the conditions of Indian service are yearly becoming harder, less attractive, and less remunerative to medical officers. The Indian newspapers abound in complaints, and some of them have published an article headed "The Dearth of Doctors." It appears that for years past the pruning knife has been steadily at work, not only on the *personnel* of medical establishments, but on the allowances, which alone redeem the drawbacks of service in the country. The reduced establishment of medical officers is already entailing heavy burdens on juniors in

the shape of frequent and sudden moves with attendant expense but without compensation. It is feared that the onerous and uncertain conditions of Indian service are already showing themselves in the depreciation both of number and quality in the candidates for admission.

At the recent meeting of the Royal Medical and Chirurgical Society a case was mentioned in which a liver abscess, which had three months previously emptied through the right lung, burst into the peritoneal sac, the accident being marked by extreme collapse. Two days afterward the peritoneum was opened, upon which a large amount of pus escaped, the sac afterward being thoroughly flushed out. After the operation the patient's condition quickly improved, so that for several months he was able to carry on his usual avocation. The case was mentioned by Dr. Hulke, as he considered it afforded an encouragement to the practice of promptly opening the peritoneal sac and flushing it out when an hepatic abscess had opened into the cavity.

Dr. Crawford Warren has, in a letter, strongly recommended the following treatment in ringworm: Wash with soap and warm water in which a little carbonate of soda has been dissolved, thoroughly dry the part, then apply acetic acid well with a brush, and about five minutes later, when the acid is absorbed, anoint with an ointment consisting of sixty grains of chrysophanic acid to an ounce of lanolin. Rub this well in and continue the treatment daily as long as may be necessary.

Several suicides of medical men have been recorded lately, and perhaps the saddest and most pathetic is that of Dr. I. A. Murray, a young man in extensive suburban practice. The death of his wife, three months ago, appears to have quite unhinged him, and the authorities were applied to with a view to his detention as a lunatic. When an officer armed with a warrant came to remove him, he calmly requested to see the paper authorizing his removal, and then, on being allowed to enter his bed-room to wash his hands, was a few minutes after found dead on the bed, poisoned. In his hand was a revolver fully loaded, and it appears likely that if the poison had failed to act speedily the revolver would have been used.

Mr. John Brook, the Chairman of the United Alkali Company, the other day before the Labor Commission, denied emphatically the evidence given respecting the injurious effects of the gas in "salt cake," some of the workers alleging that from the effects of these fumes their teeth dropped out. This and all other horrible stories which have lately been circulated are, according to Mr. Brook, pure efforts of the imagination on the part of their authors.

During the Christmas week several of the London Hospitals have been most profusely decorated with various evergreens, and on Christmas day were visited by large numbers of the friends of the patients.

LONDON, December, 1892.

Abstracts and Selections.

DIABETES MELLITUS AFTER EXTIRPATION OF THE PANCREAS.—Minkowski (*Centralbl. für allgem. Pathologie*, B. iii, No. 9) has endeavored to ascertain whether the diabetes mellitus which supervenes in dogs after extirpation of the pancreas can be prevented by transplantation of a small portion of the gland to some part of the abdominal cavity; this experiment is justified by the observation that diabetes does not appear when portions of the pancreas are accidentally left behind in the operation for removal. Dogs rendered diabetic by removal of this organ succumb readily to operation. The proposed experiment was therefore conducted thus: A healthy dog was selected, and from the tail of the pancreas a portion, connected with the body merely by a vascular stalk, was cut off and fixed to the peritoneum of the abdominal wall and also to the skin, a fistula being established. Having assured himself that no atrophy of the transplanted portion had taken place, Minkowski next extirpated the remainder of the pancreas. The dog remained free from diabetes. The disease appeared, however, when the transplanted portion was removed or when the vessels supplying it were ligatured.—*British Medical Journal*.

TREATMENT OF STRUMOUS CICATRICES OF THE NECK.—Calot (*Rev. de Chir.*, May 10th) reports two cases in which he has obtained good results by operation. In the first case the whole of the scarred skin, which measured four centimeters by three, was dissected up, together with about one to two millimeters of the surrounding normal integument. This was removed, and the edges of the wound were freed for a short distance, and then completely united with sutures, no drainage of any kind being employed. The result was very satisfactory, the original scarred surface being replaced by a fine cicatricial line, which was scarcely visible. In the second case the same method was adopted with a similar good result. Calot proposes the same plan for scrofulous ulcers, and also for ulcers which are kept up by the presence of a suppurating gland. He advises total removal of the suppurating gland, along with the surrounding ulcerating tissues and skin, and then close suture of the wound and no drainage.—*Ibid*.

ARTIFICIAL ECZEMA.—Unna (*Monats. f. prakt. Derm.*, No. 10, 1892) demonstrated to the Medical Society of Hamburg eczematous spots on himself and his laboratory servant, produced by inoculation with a special coccus, which had been cultivated from eczematous fluids. The cultivation of the coccus required special conditions as regards contact with the oxygen of the air and sufficient moisture.—*Ibid*.

THE AMERICAN PRACTITIONER AND NEWS.

"NEC TENUI PENNÂ."

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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OUR NEW DEPARTURE.

As promised in our last issue, this, our first number of the New Year, displays certain new, comely, and important features, which our many readers can not fail to appreciate.

The journal appears in the single-page book form, printed in new, clear type, with eight additional pages of reading matter, the number of pages being now forty instead of thirty-two, as in the old form. The advantages of the change are many; not the least among which are a more comely appearance, greater ease in reading, and the preservation of the shape of each number by the avoidance of folding when the journal is wrapped for mailing. Another feature of value is the ease with which reprints can be made of original articles, and the handsome book-like appearance which each brochure in future will have.

The journal has for many years been the organ of the Kentucky State Medical Society, and by means of its assumption of the form of the Society's new volume of Transactions we shall be able to handle the papers and discussions of that Society to the complete satisfaction of the Fellows, the publishers, and ourselves. That this community of interest may be understood and appreciated by all, a complimentary copy of this issue of the journal is mailed to each member of the Society who is not now a subscriber.

Our advertisers reap advantages in the better paper and clearer type in which their essays are displayed.

We have made some telling additions to our collaboratorial force, and shall, we trust, make good our *promises of loftier aims and better work.*

In consequence of difficulties necessarily encountered in the above noted changes this issue has been considerably delayed. For this we ask the indulgence of our readers, to whom we give assurance of prompt issue and delivery of, if not the next, subsequent issues.

PANCREATIC DISEASE.

For reasons not far to seek medical literature on pancreatic disease makes a meager showing. The organ is so situated as to give little, if any, evidence of its place or condition under palpation, percussion, or auscultation, and being in intimate relation upon every hand with important vessels, nerves, and viscera, the disturbances which it may occasion when diseased are almost certain to be attributed to disease or derangement of contiguous organs. Symptoms referable to disturbances of function are few, uncertain, and hard to read. These considerations, with the facts, as suggested by Dr. Noyes, that "at an autopsy generally every other organ in the abdominal cavity is examined except the pancreas," and that "the number of practitioners is small who remember when at the bedside that their patient has such an organ," are sufficient to explain why so little is known of the pathological liabilities of this important gland.

Although, since times not recent, a case of pancreatic disease has now and then been reported, the fact that the organ may be the "site of acute or chronic suppurative inflammation, abscess, fat necrosis, and apoplexies," was not generally recognized or admitted by the profession until Prof. R. H. Fitz, of Harvard, gave, in the Middleton-Goldsmith Lecture of 1889, his now celebrated treatise upon the subject.

Since then a fair number of cases have come to light, and several important contributions to the literature of the subject have been made.

Our esteemed contemporary, the Boston Medical and Surgical Journal, publishes on the 15th ult. a well-written report of a case of pancreatitis and hemorrhage, with some pertinent remarks on the clinical aspects of pancreatic inflammation, by Dr. Frank L. Day, of Providence, R. I. With this, in the same issue, appear two companion papers: one on "Acute Pancreatitis," by Prof. Fitz, and another on "Disease of the Pancreas," by Dr. Robert F. Noyes, of Providence, R. I.

These papers give practical shape to most of what is known on this obscure subject, and are therefore valuable contributions to its literature. The Boston Medical and Surgical Journal has been the medium through which most of this recent special literature has been gotten before the profession, and it is with justifiable pride that the editor calls attention to the fact that since its publication of the Middleton-Goldsmith Lecture in 1889, his journal has published six papers on the subject with reports of ten cases of pancreatic disease.

We subjoin from Dr. Day's paper his remarks upon the etiology and semiology of pancreatic disease, which are its most practically interesting features:

Acute pancreatitis is probably of more common occurrence than has been thought. It is not improbable that it is a relatively frequent factor in the course of many obstinate cases of impaired digestion, gastric and duodenal. If catarrh of the bile-duct is common, by extension from the duodenum along the common duct, why should the pancreatic duct escape? So any thing that causes gastro-duodenal inflammation may lead to pancreatic inflammation. Thus alcoholism and irregular or excessive ingestion of food are among the most frequent excitants. Hemorrhage into the pancreas, from injuries or other causes, may be a cause. The hemorrhage, on the contrary, may be consequent upon a preceding inflammation.

Symptoms. The most prominent common symptom is deep-seated pain in the upper part of the abdomen, radiating upward and backward—often sudden and intense. It is due either to (1) pressure on the solar plexus, when it is paroxysmal, colicky, and accompanied by great anxiety and oppression and often by syncope; (2) or the pain may be due to a localized peritonitis, for the front of the pancreas is covered with peritoneum (the posterior layer of the lesser omentum). In this case the pain is continuous, circumscribed, and greatly increased by deep pressure. Nausea, vomiting, and retching may accompany or follow the pain. There is constipation, and often free fat in the stools and urine; usually little temperature; often extreme emaciation. Pallor, restlessness, thirst, a rapid, compressible pulse, a furred tongue, all attest the seriousness of the illness.

The symptoms are modified by the pathological condition: pancreatic hemorrhage may occur independent of inflammation—inferentially, by analogy, due to embolism or aneurysmal dilatation (this is purely theoretical). Here the symptoms are those of sudden collapse, progressing to a fatal ending in a few minutes or hours. Again, as is probable in the present case, the fatal hemorrhage with its attending collapse may be the sequent of a pre-existing pancreatitis, and the organ at the necropsy show interstitial inflammatory changes as well as evidence of hemorrhage. Many of these cases give a history of previous digestive disturbance more or less

protracted. The pain, from being localized in the epigastrium or upper abdomen, may later become general. Tympanites is common.

Diagnosis. The diagnosis of the sudden, very acute attack involves causes of collapse located in the upper abdomen:

1. Peritonitis from perforation of (a) gall-bladder or ducts is the most frequent (this would give a history of colic, jaundice, tumor in region of gall-bladder, enlarged liver, and rigors); (b) ulcer or malignant disease of stomach, duodenum, liver, omentum or colon (easiest excluded by absence of previous hemorrhage by mouth or rectum, pain relative to ingestion of food, pre-existing tumor, cachexia, etc.).

2. Irritant poisons: History of case and character of vomitus help us.

3. Intestinal obstruction: History of case and presence or absence of obstipation aid us. Here the seat of tumor is rarely epigastric; and there is not usually localized tenderness nor general tympanites. Test by trying to inject the colon.

If the diagnosis of the final hemorrhage is difficult, much more so, even impossible, may it be to recognize the disease in its earlier stages, before hemorrhage, suppuration or gangrene occur. For, besides the hemorrhagic type, there is an "acute suppurative pancreatitis," its symptoms differing but little, save that it is usually more protracted.

Pancreatitis occasionally ends in gangrene, and we then have an "acute gangrenous pancreatitis." There seems to be no way to distinguish these forms at the bedside; it is left for the necropsy to do that.

Recovery from acute pancreatitis in the early stages is possible, but with the liability of recurrence.

INDIAN CHOLERA THEORIES.—The debate at the Medical Society of London on December 5th, on the Indian experience of cholera, was remarkable for the strong evidence adduced that the old-world "air or monsoon theory," which has so long blocked the way, is becoming obsolete. The testimony of Dr. Simpson, of Calcutta, was crucial, and he was supported by Dr. Macleod, of Calcutta, and Mr. Macnamara, always an enlightened witness to the facts of water pollution. Mr. Macnamara made a good point and caused some amusement by saying, "Mr. Ernest Hart is wrong in declaring that the prevailing monsoons have no relation to the diffusion of cholera," then adding with quiet humor, "they effect its diffusion by blowing the boats down the river, which are manned by cholera-tainted crews, thus bringing about unexpectedly human intercourse." Such a debate, in which no voice was raised in favor of "the wind," and there was practical unanimity as to "water," should leave no doubt in the mind of the advisers of the Indian Government as to their duties and responsibilities in this great matter.—*British Medical Journal*.

Notes and Queries.

MISS COBBE AND LORD TENNYSON.—In the current number of the *Zoöphilist* Miss Cobbe, true to her calling, has a notice of Lord Tennyson, with the object of parading before the public his dreadful poem called "The Children's Hospital." When this was published it naturally gave fresh offense to the profession, and its cruel imputations seriously affected some of the most kind-hearted and benevolent of our brethren. It was explained away by his friends by the fact that Tennyson was overwrought on having depicted to him some of the experiments made on animals by continental physiologists, and they declared that he bore no ill-feeling toward the medical profession generally, nor could he, seeing that he numbered among his friends some of the most eminent medical men in London, some of whom had openly expressed their opinion as to the value of experimentation. They have said he was only describing a particular wretch whom his own fancy formed. In spite of the explanation which has been often given by his true friends and admirers, Miss Cobbe quotes some of his lines where the surgeon is said to have been "happier using the knife than in trying to save the limb," and declares that Tennyson describes the typical experimental surgeon, and then she goes on in her usual damnatory prophetic spirit, aided by that inner light which she boasts, to inform the profession what its future will be. She says: "Happily the vivisectors are excluded from the ranks of the immortals, and their names, if they do not perish, will go down to posterity covered with the infamy of Herophilus of Alexandria and of Majendie." All this rubbish is wisely unnoticed by the profession, but now that attention has been called to it, it is only worth quoting in order to exonerate those who, having these insults put upon them for so long a time, have retorted (without imprecations) in no uncertain language.—*British Medical Journal*.

M. RENAN ON EUTHANASIA.—M. Renan, whose death is mourned so widely, published in his *Souvenirs de Jeunesse* his thoughts on this subject. It is one which is familiar to the thoughts of medical men, and one on which in the course of the sad incidents of practice, these thoughts are often elicited by anxious patients. M. Renan wrote: I have only one petition to make to the good genius who has so often guided, counseled, and comforted me—a sudden and painless death at the allotted hour, be it early or distant. The most desirable death is that on the field of battle. If at times I may have desired to be a senator, it is because I imagined that at no distant date, perhaps, that position will afford an occasion to be shot or killed in a way far preferable to a long malady that destroys you slowly and

by inches. God's will be done. . . . I should be saddened at having to go through one of those periods of gradual dissolution, when a man who has had strength and virtue is but a shadow and ruin of himself, and often, to the delight of fools, labors to stultify the whole edifice of his former life. Such an old age is the worst gift of the gods to man. If such a fate were in store for me, I protest in advance against the weaknesses that a softened brain might prompt me to speak or write. It is the Renan sound in mind and heart, such as I am to-day, not the Renan half destroyed by death that I shall be if I am doomed to slow decomposition, that I wish people to believe and listen to. The life which was given me unasked has been for me a blessing. If it were once more offered me, I should gratefully accept it. The century in which I have lived will probably not rank as the greatest, but will doubtless be held as the most amusing of centuries. Unless my remaining years have cruel pain in store for me, in bidding farewell to life I shall only have to thank the cause of all that is good for the charming excursion that it has been given me to take through reality.—*Ibid.*

CIGAR ENDS FOR SALE.—If it be true, as stated in evidence on behalf of the Commissioners of Internal Revenue, that a large illicit trade is being done in making up cigar ends into cigars, it is difficult to conceive a more filthy trade or one more dangerous to health. Of course so far as such "illicit" cigars are burnt away they are "purified by fire," but the ends which are sucked can hardly fail to be often contaminated with germs of a variety of foul diseases. The traffic should be stopped by all means. Discarded cigar ends should be "cremated."

Special Notices.

F. COLET LARKIN, M. B. and C. M., of Kingsbridge House, Avenue Road, East Cliff, Ramsgate, England, on January 10, 1892, writes: It may be of interest to you to know that I have had a most satisfactory result from the administration of your BROMIDIA in a case of sleeplessness, after a slight apoplexy, with partial paralysis of the right cheek and arm. The patient (male, sixty-three years old) suffered from weak heart, and before coming under my care had been given sulphonal, paraldehyde, etc., without sleep being obtained. The first night here he received one dram of BROMIDIA and got seven to eight hours' quiet sleep without any ill after-effect from the drug. The same dose continues to give the patient some hours' sleep every night.

The usefulness of good Hypophosphites in Pulmonary and Strumous affections is generally agreed upon by the Profession.

We commend to the notice of our readers the advertisement in this journal. "Robinson's Hypophosphites," also "Robinson's Hypophosphites with Wild Cherry Bark" (this is a new combination, and will be found very valuable) are elegant and uniformly active preparations, the presence in them of Quinine, Strychnine, Iron, etc., adding highly to their tonic value.

THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNĀ."

VOL. XV.

LOUISVILLE, KY., JANUARY 28, 1893.

No. 2.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

A CASE OF SCIRRHUS TREATED BY INTERNAL MEDICATION.

BY T. P. GRANT, M. D.

I am led to report this case, in view of the very uncertain results obtained by the most careful operators in the treatment of cancerous diseases by the use of the knife. The happy results obtained by me were unexpected, and I trust that this report may lead others to investigate the value of the treatment here given, if happily it may be proven that we have a remedy that, if it does not cure, will at least palliate the horrors of cancer.

At some future day, when I shall have carried my investigations further, I shall make a more extended comment on the subject of cancers. For the present I give a history of the case without comment.

Mrs. X, widow, multipara, age sixty-eight, consulted me in March, 1891, in reference to a tumor in the right mamma. She gave the following history: Some six years ago she was struck on the right breast by the back of a rocking-chair. After a few days, the pain passing away, no attention was paid to it. Some time afterward, on reaching up to light the gas, she felt a sharp pain at the point where she had been struck. Upon examination she found a hard place. This continued to grow in size and darken in color, with occasional sharp, shooting pains, till she became alarmed and consulted me.

The family history presented by this case is remarkably good, there being no history of cancer, tuberculosis or specific disease in her family or her husband's family, either direct or collateral.

Upon examination I found a well-preserved woman of good weight, with a well-marked carcinomatous cachexia; the right mamma rather small—in it a nodular tumor about the size of a goose egg, with its long axis at an angle of forty-five degrees from the vertical; on the lower margin a blue-black spot the size of a silver dollar. Near the upper end of the tumor was another black spot. The color gradually faded from these spots over the whole mamma. The skin was firmly attached to the tumor at these spots, and was hard and smooth, looking more like polished marble than human skin. The nipple was retracted, in fact looked as if it was turned wrong side out. The tumor was firmly adherent to the chest wall, any attempt to lift it causing pain.

Strange to relate, a most careful examination failed to disclose any enlarged lymphatics. My diagnosis was tuberos scirrhus.

In view of the age of the patient and the almost absolute certainty of a return after the operation I advised against surgical interference, the best authorities agreeing that in elderly persons the operation rarely prolongs life but a few months. After hearing all the facts in the case the patient and her friends accepted my advice and decided not to have an operation. They naturally wanted to know if something could not be done without the use of the knife, which promised so little.

Having had most excellent results from the use of syrup trifolium compound (Parke, Davis & Co.) as an alterative, I determined to put her on this preparation, that her system might be in the best possible condition before the breakdown came, when the tumor would ulcerate. This I ordered to be taken in teaspoonful doses three times a day. I also directed a pill of hydrastin $\frac{1}{4}$ grain and podophyllin $\frac{1}{20}$ grain to keep the bowels open as needed.

The whalebones having been taken from the right side of the corset, the breast was dressed daily with this ointment spread on a cloth:

| | | | |
|----|----------------------------------|---|---------|
| R | Sebi ovis, } | | |
| | Ol. olivæ, } | āā | 3ij; |
| | Ceres flava, | | 3ss; |
| | Zinc oxid., | | 3iij; |
| | Ext. eucalyptus glob., | | 3j; |
| | Acid. carbolic, | | grs. C. |
| M. | Fiat ung't. | Sig: Grant's oxid. zinc ointment (comp.). | |

This ointment is a great favorite with us, but in this case was used to prevent friction, as the friction of the clothing produced pain. As the mamma was to be carried in a sling she used an old silk handker-

chief on account of its softness. The patient was directed not to use her right arm more than absolutely necessary, to do no work or sewing, take a great deal of open air exercise and keep cheerful company.

In ordering this line of treatment I assured the family it was not expected that it would effect a cure, but merely to put her in the best possible condition for the inevitable, and to delay the breaking down as long as possible.

This treatment was faithfully carried out till September, 1891, when I again saw the case. The cachexia was gone. Her complexion was so clear as to cause remarks by her friends. Upon examination I found to my surprise that the skin was no longer hard and shiny, and the discoloration had almost entirely disappeared; only the lower place that had been black was discolored, and that only a pale blue. The tumor was greatly reduced in size, and no longer adherent to the chest wall. The nipple was not so retracted.

Early in November, 1891, I again saw the patient. The general appearance showed a progressive improvement, but in the place where had been the center of the original large dark spot there was an opening the size of a crow quill, discharging a thin ichorous fluid, I suppose as much as two fluid ounces in twenty-four hours. The nipple did not project as much as normal.

I ordered the same treatment continued, with the addition that the cavity was to be washed out with hydrogen peroxide (Marchand), one part to three of boiled water, using a small syringe, the injections at each sitting to be repeated so long as the returning fluid was frothy, after which there was to be injected a syringe of the following:

R Methyl violet (Merke), grs. v;

Aquæ, ʒij.

M. Sig: 5 to 10 drops in ʒj of boiled water.

The breast to be dressed night and morning. The discharge grew less and less each day, till at the end of six weeks I had the satisfaction of learning that the opening was healed. The general condition continued to improve till February of 1892, when there came another opening about the same size and place, discharging the same thin ichorous fluid, attended by slight hemorrhage. On this occasion the discharge ceased, and the opening healed entirely in three weeks under the same treatment.

I examined the patient carefully a few weeks ago, and found no discoloration of the skin, the tumor not half so large as when I first saw

it. The breast is larger, and can be moved with little or no pain; nipple normal, and rarely in pain; in short, the patient is in an exceptionally good physical condition for a person of her age.

I am free to say that I think it possible the breast may open again; but, having succeeded in healing it twice and made progress in reducing the tumor and improving the physical condition of my patient, I do not look to the opening with any apprehension.

What the final outcome of the case may be, the future only can reveal; but at this time she is certainly in a more favorable condition than she was fifteen months ago.

In conclusion, I would say that the utmost care was used in this case that there should be perfect asepsis.

LOUISVILLE.

RIGOR MORTIS FORENSICALLY CONSIDERED.

BY R. A. PRICHARD, M. D.

Directly after death a season of flaccidity is present. This limp period lasts an hour or so, and then the body begins to stiffen. The flaccid state is more apparent than real, for the *turgor vitalis*—vital turgidity—has departed, and a passive limberness succeeds. The degree of pliancy can not be assumed in life, and is hardly attained in profound anesthesia. In an hour or so after death the phenomenon of suppleness is followed by a loss of pliancy which ultimates in a pronounced degree of stiffness, slight at first, but an accentuated rigidity in the course of five or six hours. At the close of one hour after death the rigor is too slight to be observed by the unprofessional, yet in two hours there is enough stiffness in the fingers, the eyelids, and the under jaw to be noticed by persons who are preparing the corpse for burial.

At the termination of three hours a considerable degree of rigor is observable, and at the end of four or five hours there is so much rigidity that it would require some force to flex the large joints. After six or seven hours have passed the *rigor mortis* is pronounced, and extends to all the muscles of the body and to the soft tissues generally, the cooling process serving to chill and harden the gelatinous substances. The cadaveric rigidity lasts from twenty-four hours to several days, and

the *post-mortem* contractility in the muscles gives way to a flaccidity or a softness peculiar to a body undergoing decomposition. The body no longer retains rotund aspects, but passively flattens, parts pressing upon projecting substances being deeply indented. This softness of decomposition is to be distinguished from the pliancy of a body still warm after death.

If the weather be freezing, the period of extreme flaccidity between death and cadaveric rigidity is lessened perceptibly—the period being abridged to a little more than half an hour—and the *rigor mortis* sets in a little earlier than it otherwise would and becomes more pronounced. However, the rigidity of death is not perceptible by the unprofessional until two or three hours have passed. The undertaker and the expert autopsist might detect a degree of stiffening in a body dead an hour, especially if the corpse have been exposed to nearly a freezing temperature.

In cholera patients and in persons dying of intestinal occlusion there is a degree of stiffening in the hands and feet which is perceptible before death. The *ante-mortem* rigidity is not always succeeded by a perceptible amount of pliancy which usually follows death.

Not much confidence is to be placed in the statements of the unprofessional who allege that sudden death, as by lightning, is not succeeded by *rigor mortis*. The stories about soldiers dying in the heat of battle and continuing in the attitude of fighting are to be taken *cum grano salis*. It is reported that a cavalier at the battle of Balaklava was killed in the saddle, and continued in his seat while his unhurt horse carried the lifeless trunk through renewed onsets.

The body of a woman is found at a certain hour with her throat fatally gashed, or with a bullet hole in her side or forehead, and her husband says that he left her at work a half an hour previously; and it is observed by friends that the cadaveric rigidity is marked at the dressing of the corpse an hour after the alleged suicide. The husband may be charged with homicide on the ground that he has told an untruth in regard to the time he left his wife sound and well. Cadaveric rigidity would not come to pass so soon, hence the significance of the false statement. Then with the false allegation there should be circumstantial evidence of value in surroundings—where is the weapon found? A razor or a pistol may be made to do suicidal work, and then be thrown to a distance by the one employing it with deadly effect as a weapon. The physician can observe the nature of the wound, and be able to

state whether it be palpably suicidal or homicidal; or be able to demonstrate why it is not suicidal. A throat cut of a suicide begins on the left side of the neck, if the individual be right-handed; a would-be homicide usually cuts deeper than a suicide, severing the trachea. A woman attempting suicide with a razor rarely cuts deep into the trachea; she has not the strength, or fails to put it forth. A woman might throw a knife with which she had stabbed herself, or a razor with which she had cut her throat, yet she could not throw a pistol whose discharge had lodged a missile in her heart or brain. The hand might convulsively clutch the weapon, whether it be knife or pistol, and the succeeding *rigor mortis* continue the grasp.

The hand which cuts a throat, whether it be homicidal or suicidal, is always splashed with blood; yet the hand holding and firing a pistol may not have a blood stain upon it. The clothing may keep blood from appearing on the floor where the body falls or rests; extravasated blood coagulates in a few minutes. If a murderer receive a bleeding wound in a scuffle, dripping blood may leave stains which indicate the direction taken when the escape is made. A suicide, living a few minutes after the fatal wound is inflicted, may, in a semi-conscious state, walk or crawl some distance into an adjoining room. A murderer might place a pen firmly in the stiffened fingers of his victim, and even make ink scrawls, as if the dying suicide had attempted to indite a message.

Death from convulsions of strychnia is followed by a short period of flaccidity, which is early succeeded by *rigor mortis*, and the cadaveric rigidity is not lasting.

Fatal poisoning with arsenic, hydrocyanic acid, and opiates leaves the body much as it is after the termination of a course of fever resulting fatally. It is to be remarked that when the rigidity of death is once broken up it never returns again. Students in dissecting, who break the stiffness of an elbow or knee to secure a more desirable position, will remember that the normal rigidity of a corpse does not return. If pronation and supination of the forearm be to their full extent in a cadaver, the mobility thus established is never lost.

It is not uncommon for a corpse to present lividities, or *post-mortem* discolorations, which are not true ecchymoses, or stains produced by the extravasations of blood before death. They are usually seen in dependent parts of the body, and must be distinguished from the true ecchymoses of bruises sustained during life. When clothing presses

upon a dead body there develop vibices, or linear discolorations, as if the parts had been striped by the lash of a whip or switch. The *post-mortem* stains of the body that has lain in water, as one case especially I call to mind, are denominated suggillations. The stains exhibited on the dependent parts of the body laid out for burial are hypostases. The coloring matter of the blood is carried downward by gravity. I noticed after a short time an abundance of these in the thoracic region of a woman crushed to death by a crowd panic-stricken at an alarm of fire in a theater. Death occurred at three P. M., and the hypostases were marked the next morning. Extravasated blood was found inside of the thorax. The outward discoloration was in part a sequence, I believe, of asphyxia. I have often seen it about the necks and chests of the asphyxiated.

GARNER, KY.

TECHNIQUE OF SUPRAPUBIC CYSTOTOMY.*

BY JAS. S. CHENOWETH, M. D.

Assistant, Surgical Clinic, University of Louisville.

I would like to present, as a basis for discussion, a few points relative to the technique of suprapubic cystotomy. I have been impressed in all these operations that I have seen with the importance, not only of a strict regard for the indications to be met in each individual case, but also with the importance of a strict attention to detail in meeting them, if we would receive the greatest possible good from our operation.

Viewed from the standpoint of the technique, I think we can properly divide our cases into four general classes:

The first class, including the recent cases of stone and foreign bodies and small pedunculated growths, where the bladder is only moderately or not at all diseased.

The second class, including the neglected cases of the first class, where severe inflammatory changes have taken place in the bladder walls.

The third class includes the cases requiring removal of tumors or prostatic outgrowths, or prolonged drainage for cystitis.

The fourth, that not inconsiderable number of old neglected strictures of the urethra, in which a guide can not be passed for the perineal operation, and in which retrograde catheterization of the urethra is desired.

* Read before the Louisville Surgical Society, December 12, 1892. For discussion see p. 53.

In the first class no especial preparatory treatment is requisite beyond emptying the bowels by laxatives and enemata, irrigating the bladder with boric-acid solution, and cleansing and shaving the abdomen.

The anesthetic, preferably chloroform, being administered, an oval rubber bag with tube attached is introduced into the rectum. By means of a soft catheter and a hand syringe the bladder is filled with warm boric or Thiersch solution, the quantity being regulated by the known capacity of the bladder and the sense of resistance imparted to the hand; this is retained by an elastic band around the penis and a clamp on the catheter. The rectal bag is now slowly and carefully injected, and the bladder may be felt in contact with the abdominal wall above the pubis. A three-inch incision in the median line, just above the pubic bone, carried down between the recti and pyramidalis muscles, exposes the prevesical space and the bladder wall presenting, covered by a thin membrane containing more or less fat; this fat, which contains the peritoneum, is rolled up from the symphysis, care being taken not to disturb the lateral attachments of these loose tissues. This little maneuver is often much abused, and operators in a frantic effort to avoid the peritoneum, which is in no danger if the bladder and rectum have been properly injected, so loosen up the attachments behind the symphysis and around the neck of the bladder that urinary infiltration and consequent cellulitis are inevitable.

The bladder being exposed, any large veins on its surface in the line of proposed incision are ligated with fine catgut by means of a sharply curved needle, a strong silk ligature is passed deeply into the wall of the bladder, which is incised just below by a clean thrust of the knife. This ligature serves to hold the bladder in contact with the abdominal wall after the incision, and diminishes the risk of tearing loose the anterior attachments while punching around in the bottom of the pelvis trying to find the opening in the now collapsed organ.

The incision in the bladder should be of sufficient length to permit of the easy removal of the foreign body without tearing and bruising the edges of the cut. Guided by the ligature the finger is quickly introduced and the body removed. After thorough irrigation, the bladder still being held up and steadied by the ligature, it is closed with numerous interrupted sutures of over-prepared catgut, carried down to the mucous coat, or, in some cases, an oval surface may be denuded around the incision and the broad, fresh surface thus formed united by

two rows of continuous suture. A small drainage-tube is laid over the line of suture and brought out at the lower end of the external wound, which is closed down to this point. A soft catheter introduced through the urethra and tied in completes the operation.

In the second class, with inflamed, contracted bladders, effort should be made to cleanse them, and at the same time gradually dilate them to a reasonable capacity before operation, and unusual care taken against rupture when the final distension is made under anesthesia. The operation is completed, as in the former class, up to the point of closing the bladder wound.

It being evident that the wound of an acutely inflamed and contracted bladder will not unite primarily, no attempt should be made at closure, but drainage should be free; this may be done by a tube carried to the bottom of the bladder and retained by fastening to the skin, or by a perforated hard rubber plate with straps carried around the abdomen. The end of this tube may be left long, and drain into a vessel at the bedside. If the tube causes much pain and is forced out, it is often impossible to replace it; this seems to be of little moment as far as the bladder is concerned, as it will drain and can be thoroughly irrigated without it, but the patient is kept continually well by the flow of urine.

In the removal of tumors or prostatic outgrowths from the bladder by the suprapubic method the rectal bag should be distended as far as safety will permit, thus forcing up the base of the bladder and greatly facilitating the work.

The Trendelenburg position is also of great service here, bringing the parts well into view. After the removal of these growths there always arises the necessity for thorough drainage for a considerable length of time, and in the case of old cystitis the drainage may have to be permanent. This drainage, in my experience, can not be well accomplished without fastening the bladder to the abdominal wall; the tube almost invariably slips out or has to be removed on account of clogging up or becoming incrustated with urinary salts, and it is often impossible to replace it through the long sinus running down to the bladder. This sinus contracts rapidly, and unless the obstruction at the bladder neck has been perfectly removed the cystitis will return, and not only will there be no benefit derived from the operation, but a small discharging sinus will add misery to an already miserable being.

In opening the bladder for retrograde catheterization of the urethra in impermeable stricture, the rectal bag should not be used; the blad-

der is usually diseased and distended and the danger of rupture great. A little care in stripping up the prevesical fat is all that is needed to avoid the peritoneum. The opening should be small, and as a rule immediate suture practiced, free drainage being kept up through the perineal opening until union is complete.

LOUISVILLE.

Reports of Societies.

THE LOUISVILLE SURGICAL SOCIETY.*

Stated Meeting, December 12, 1892, Dr. A. M. Cartledge, President, in the chair.

Dr. W. C. Dugan: I have a case of cerebral surgery that I would like to mention: A lady, about fifty years of age, has had great pain in the head for eight or ten months, and it has steadily increased. She has been treated by a number of physicians by various lines of treatment, and she has grown gradually and rather rapidly worse. Her hearing was at first but slightly involved, but latterly to such an extent that she could hardly hear at all. During the last few weeks I am confident there has been marked impairment of intellect. I saw her for the first time several months ago, and then did not see her again for about two months; meantime her physician asked Dr. Dabney to make an examination, and he reported double choked disk, the right more marked than the left. Later she had partial paralysis of the right leg, twitching of the right side of the face, and incomplete loss of sensation of the right arm. Diagnosis of tumor was made, its most probable location being left side, about the upper part of the fissure of Rolando. She had two convulsions during this time, whether unilateral or bilateral I am unable to say, but they were rather severe, followed by considerable stupor. Exploratory operation was advised for the purpose of finding the tumor, the understanding being if it could be removed it would be done. A very large semi-circular incision was made over the left parietal bone, the flap turned down, leaving the periosteum intact. After going through the periosteum and turning it back separately we took a large-sized trephine, expecting to take out a large button, but

*Stenographically reported by C. C. Mapes.

found it slow work, the skull being very thick. I then decided to take out a smaller sized button. The bone was removed, and the membrane bulged up almost half way through the skull, very tense, and felt almost like wood. I then took a chisel and mallet and cut out this entire two inches of bone, the size of the original trephine. The tension was so great that the membrane came up almost on a level with the outer part of the skull. The dura was then incised, and to my very great surprise, and perhaps I should say my chagrin, the brain just welled up almost like quicksilver through this incision in the dura. There was a mass of cerebral tissue as large and thick as your finger pressed through the opening in the dura, and the constriction was so great and the tension from within so much that it produced intense engorgement. The dilemma was not one to be envied, I assure you. I did not know how to close the dura. Knowing that there must be something to account for the great pressure, I explored with a hypodermic needle and found no fluid. I then took a groove director and passed it down to the ventricle, and found a large quantity of fluid in the left cavity—at least three ounces, and perhaps more. As the fluid flowed through the groove the brain naturally settled back in its place, and at the conclusion of the aspiration I was able to pass my finger around into the dura, palpating the brain so as to ascertain whether there was a tumor anywhere. No tumor was discovered. I then thought best to pass the groove through the septum to the other ventricle to see if any fluid existed there. This was carefully done, but no fluid found. The dura was then closed and the scalp sutured, no drainage being used, and the patient dressed and put to bed. She reacted well from the operation, there being no shock. She has had some little trouble since with loss of speech, but she is able to articulate some sounds distinctly and intelligently. She has suffered very little pain since the operation, and has been doing very well. Instead of finding a tumor we discovered an accumulation of fluid in the left ventricle, the pathology of which I am unable to give. The fluid seemed to be perfectly clear, and whether it was tubercular or otherwise I am unable to say. The future of the case is purely one of conjecture; I am not prepared to say what the outcome will be. Her physical condition is good; the operation was done one week ago, and she sat up to-night and is suffering no pain. The paralysis has been relieved, but her hearing has not returned. I can not help believing that the trouble will return, and that the end is not very far off.

Dr. A. M. Cartledge: How long was it after the operation before the paralysis was relieved?

Dr. Dugan: Right away. Sensation now seems to be hyperesthetic. Before the operation, as she could not hear, her family would write messages on paper and she would look at it for a long time and eventually she would understand it; then she would wait four or five minutes before answering a question, showing that her intellect was greatly impaired. I left the bone out for two reasons: First, it could not have been replaced, as, after taking out a button with the trephine, the opening was considerably enlarged with the chisel; further, I would have left the button out anyway, so as to have the advantage of that amount of lack of resistance, and in the event that the fluid re-accumulates it can be aspirated with less trouble. The opening left in the skull, as nearly as I can judge, was about two inches in diameter. The only hemorrhage experienced was from separation of the dura. If I had not explored the brain I would never have been able to have brought the edges of the dura together.

Dr. A. M. Vance: I think it is a wise thing that the doctor left out the button of bone. If there is re-accumulation of the fluid, the relief from pressure will be of great advantage.

Dr. E. R. Palmer: A young man came to me a year ago, having been married three years, with gleet and stricture of the urethra, with the statement that his wife was barren and he wanted to be cured; that his wife also had trouble, which he believed she had contracted from him, and that he also wanted me to treat her. I operated on him for stricture by the Otis operation, treating him for a long time, and at the same time treated his wife, who had chronic vaginitis and chronic endocervicitis, with a deflected, fixed uterus, a condition that we nearly always find where a woman had contracted gonorrhea, the deeper membranes being invaded. This man was entirely cured of his gleet and stricture, and his wife was very promptly relieved; her vaginitis disappeared, the discharge from the uterus disappeared, and she was in excellent condition. I saw the gentleman a few days ago, and he said he was happy to report that he was the father of a bouncing girl.

No. 2. About six months ago, when the pregnancy of the patient above referred to was well assured, another man, employed by the same corporation, came to my office with his wife and asked me to make an examination and try to determine why his wife never had any children, and treat her for barrenness. I told him this was rather out of my line,

suggesting his consulting Dr. Turner Anderson. He then made the statement that he had applied to me because of my success in the other case reported. He said he had been married two years and his wife had never conceived, and as I had treated Mr. and Mrs. So-and-so, who had been married three years, and his wife was pregnant, he wanted me to see what could be done in his case. I made inquiries as to whether either of them had ever had any trouble of a venereal nature, and he replied that they had not. I took them both over to Dr. Anderson's office, and they were examined separately. This woman was a magnificent specimen of womanhood, weighing about one hundred and fifty pounds, apparently in perfect health, vagina and womb normal in position and size; in other words, her entire sexual apparatus was in a perfectly normal condition. I then took the man in an adjoining room, and he confidentially gave me the history, that several years ago he had contracted gonorrhea, with double epididymitis, but stated that he had been cured for a long time before marrying. I instructed him to have connection with his wife and bring me some of the semen for examination. He did so, and it was found to be utterly devoid of spermatozoa, proving beyond all question why his wife had never become pregnant.

It is stated that in ten cases of barrenness the woman is at fault seven times, the man three.

Dr. Jas. S. Chenoweth read an essay on Suprapubic Cystotomy. [See page 47.]

DISCUSSION.

Dr. W. O. Roberts: I have had considerable experience in the operation of suprapubic cystotomy for stone, for cystitis, for tumor, and for draining the bladder in old cases of enlarged prostate. In some cases I have used the bag, and in others operated without it. I believe we can get along just as well without as with it. Where we want to operate on the prostate, I think we can be better aided by an assistant introducing his finger into the rectum and pushing the prostate upward and forward than with the bag. I have never found it necessary to tie any vessels in the bladder wound. As soon as the bladder is emptied, distension of the vessels will disappear and the hemorrhage will cease. I reported, I think, to this Society some time ago a very interesting case, patient of Dr. Palmer's, where I operated for tumor of the bladder by the suprapubic method. The tumor in this case obstructed the flow of urine through the urethra; after closure of the suprapubic wound the man was able to pass water by the urethra, throwing it three feet from

him. This is not the usual result in such cases. As a rule they do not recover the power of completely emptying the bladder through the urethra.

Dr. Palmer: I am forced to believe that the modern operation of suprapubic cystotomy will eventually find its proper place to be when it has been fully determined that the old-fashioned operation through the perineum is not admissible.

With reference to the case just spoken of by Dr. Roberts, I believe that probably the perineal operation with curetting would have relieved the man with less after-trouble. I believe that in the majority of cases where operations of this sort are done on the bladder, the tone of the bladder is so permanently destroyed that we can not expect to restore the normal action of this organ through the natural passages. In the case Dr. Roberts has spoken of the result was all that could be desired; but I was impressed in that case, as I have been in a number of others I have witnessed, that if any man thinks it is a comparatively simple operation to go into the bladder above the pubes, he is the worst fooled man that ever took a knife in his hand. It has impressed me as being one of the most tedious, difficult, and deceiving operations that a man can attempt. For my own part I do not expect to do, in my particular line of work, a great deal of this form of surgery; but when I do it, my own preference is to go into the bladder, where it is possible, through the perineum. I have no doubt that men with larger experience and greater statistics to back them up than I am possessed of are anxious, ready, and hopeful in the matter of preference of suprapubic cystotomy, notwithstanding the almost certainty of more or less permanent fistula, which is one of the serious objections to the operation. I would always exclude the feasibility of operation through the perineum before resorting to suprapubic cystotomy.

Dr. Dugan: I have enjoyed the paper, and consider it a most excellent one in the main, but I can not refrain from taking issue with Dr. Chenoweth in reference to the use of the rectal bag, also the use of water in distending the bladder. In the first place I do not believe that the rectal bag is of any service whatsoever in suprapubic cystotomy, and that if the rectal bag is indicated at all, it is after the bladder has been opened. It might be well enough then, if you are operating on the prostate or base of the bladder, or for tumors where you want to bring the prostate up as high as you can, to insert the bag. There is always danger of rupturing the bladder and rectum by distension and

pressure from use of the rectal bag. I think it has been demonstrated beyond a doubt that we can not elevate the fold of the peritoneum by distending the rectum by the rectal bag; you simply push the prostate and bladder up toward the symphysis. I do not believe the bladder should be distended until after we expose the prevesical fat, it being easier, in my opinion, to cut down upon an empty rather than a full bladder. After you have made your incision, exposing the prevesical fat, have your syringe ready and let the assistant fill the bladder with fluid, and you can feel the fold of the peritoneum slip over the finger; when this sensation is felt, then have the catheter tied around the penis and the bladder opened.

While suprapubic cystotomy is attended with considerable danger, still I do not think the mortality should be over five per cent in young, healthy subjects; but in old men and patients with chronic disease of the genito-urinary passages it must necessarily be high.

I think the doctor's precaution of suturing the bladder to the abdominal wall by a silk ligature is an admirable one, and should not be overlooked. Suturing the bladder is a very important matter if we use silk. It is difficult to get the edges so accurately brought together that the ends of the suture will not fall through. I operated upon a patient some time ago and had this misfortune to follow, a piece of the suture material dropped into the bladder through the incision, around which a calculus formed requiring a second operation.

In regard to drainage, I believe in these cases there is nothing equal to iodoform gauze. I think it is better than a tube, and gives the patient much less pain. It is necessary to be very careful to have your gauze well protected, all the little threads removed, and wrapped with silk, so as to be doubly sure that you are not going to leave any of the threads in to cause the formation of calculi. I do not think the operation of suprapubic cystotomy advisable in impermeable stricture of the urethra; I have yet to see a case that could not be relieved by simple operation, either by external urethrotomy without a guide, or by the perineal method. I agree with Dr. Palmer that suprapubic cystotomy is an operation of considerable magnitude, and was somewhat surprised to hear Dr. Hunter McGuire state, at the meeting of the Southern Surgical and Gynecological Society, that the operation was as simple as the opening of a boil. I am sure he made a mistake in that. At any rate it does not appear so to me. It is an operation which requires an accurate anatomical knowledge and perfect surgical technique.

Dr. W. L. Rodman: I am very much disposed to accept the steps of suprapubic cystotomy, as given by Dr. Chenoweth, as being the proper ones. I believe that in the majority of cases it is better to use the rectal bag. It has been demonstrated that you lift the peritoneum and bladder higher by use of the bag than you can possibly do without it. I believe that the danger in using the rectal bag has been overestimated. It seems to me that it is a very weak bladder if it is going to be ruptured by use of the rectal bag. I have always used the bag, and shall continue to do so in every instance. Instead of ligatures I use two tenacula to bring the bladder well into view, and think this is the ideal way of lifting the bladder up into the abdominal wound. I do not like the use of ligatures for this purpose; they tear out and do more damage to the bladder wall than tenacula properly used, their introduction is also more tedious. I agree with Dr. Roberts in regard to hemorrhage; it nearly always ceases as soon as you have opened the bladder.

I also agree with the essayist in the position taken concerning suprapubic cystotomy for so-called impermeable stricture. It occurs to me that suprapubic cystotomy, while not an easy operation by any means, is both easier and safer than perineal section without a guide. I have a case now that I propose to do a suprapubic cystotomy on next Wednesday or Thursday. It is a case of impermeable stricture that I have tried to enter twice, and rather than do a perineal section without a guide I shall perform suprapubic cystotomy. I am very frank to say, however, that I have never in my life failed to get into the bladder through the urethra when the patient was put under chloroform. After putting the patient just mentioned under the influence of chloroform, if I fail to enter the bladder through the urethra, then the suprapubic operation will be resorted to.

Dr. H. H. Grant: I was very much surprised to hear Dr. Dugan begin his discussion by stating that suprapubic cystotomy was so simple as to be readily done without the use of any artificial means to raise the bladder up; afterward to state that the mortality was only five per cent, then to criticise Dr. Hunter McGuire for teaching medical students concerning an operation as serious and grave as this one is. I think it is a very serious matter for surgeons of reputation and ability to educate young men to believe that any surgical operation can be done without great danger, or without considerable skill at the best to avoid this danger; that every means possible to make it easier and safer should be employed, and that no methods which have received the approval and

support of experienced and competent surgeons should be discarded or condemned without some definite reason therefor. I am firmly persuaded that in all operations of suprapubic cystotomy that I have witnessed, and there have been quite a number, without the bag, that the peritoneum has appeared in the wound. I am also convinced that it is rarely seen where these means are employed. A little difference is always to be found in the resistance of the tissues upon the live and dead body; the majority of experiments which have been employed to determine how far the peritoneum could be pushed up have been upon the dead body. Ability to push up the peritoneum and bladder by artificial means experience has shown to be very considerable, and in many cases the peritoneum has been found to be pushed three inches above the pubis, so far that there is no possibility of injuring it in the first incision, and easily pressed out of the way by the finger without any fear of wounding it. Certainly no danger can be experienced in distending the rectum with eight ounces of fluid in a rubber bag. When the plane which supports the prostate and the rectal base of the bladder has been raised toward the level of the pubic arch by distension of the rectum, the peritoneum will be proportionately higher as a matter of simple mechanics, and when the bladder is afterward filled with the solution the fold of peritoneum rises much more readily.

Dr. Dugan: Right at this point I would like to ask the speaker if he believes that eight ounces of fluid in a rubber bag will lift the bladder up three inches?

Dr. Grant: I have already stated that in all the operations I have seen, and there have been more than a dozen of them, in which the rectal bag was used the peritoneum did not appear in the wound. If the peritoneum is not pushed up three inches, it is certainly pushed up some; and with this precaution the peritoneum has not appeared in the wound where the rectal bag was properly distended, and the bladder was distended afterward. Upon the dead subject I have done this operation over one hundred times, and occasionally the peritoneum would be encountered. In a few instances it dropped down quite upon the pubis; but in these cases it was not pushed up either by distension of the bladder or distension of the rectum.

Of course in my remarks I simply refer to my experience, and my observation is corroborative of the wisdom of taking all means to prevent any possible wounding of the peritoneum, which is almost certainly a fatal accident, unless the peritoneum be promptly closed up

without any chance of infection. I looked upon the operation, proper care being taken, as one comparatively easy to do. I look upon it as even less attended by risk than the operation which Dr. Palmer prefers, as far as the operation itself is concerned.

With respect to the hemorrhage which occurs after this operation, as far as the simple operation is concerned, I agree with Dr. Roberts that it is rarely troublesome. In operations upon the bladder for the removal of tumors, and especially in prostatic troubles, the danger of hemorrhage is very considerable, and it has been the practice of some to cauterize the bladder with a hot iron or thermo-cautery. A safer step is to tampon the bladder with graduated gauze, fixed by a thread drawn out by a perineal wound or through the urethra, as suggested by Keyes. There are a number of points with respect to the management of this operation presented in the paper that meet my approval thoroughly. It should be the object of every surgeon to avoid injury to the peritoneum in operations of this character, and I believe we ought to employ every possible means in order to prevent injury. The details of the technique which Dr. Chenoweth has given us are both interesting and adequate, and are much upon the original modifications by Petersen, and having stood the test of time are to be relied on.

Dr. Dugan: I am a little surprised at the position taken by Dr. Grant in reference to my former remarks. I did not mean to criticise Dr. Hunter McGuire, except in so far as his statement that "suprapubic cystotomy is as simple as opening a boil." I agreed with Dr. Palmer that it was an operation of considerable magnitude. Now the point I wished to make was, the best means of avoiding the dangers in this operation were by taking the precautions which I have mentioned, that is, not to distend the bladder until you expose the prevesical fat; and in order to locate the peritoneum after the bladder is exposed, if you will follow the precaution now being practiced by the best surgeons in America and Europe there will be no danger of wounding the peritoneum; that is, to first distend the bladder, then slip your fingers well down toward the neck, letting the bladder up into the palm of your hand until you feel the fold of the peritoneum slip above, then the bladder can be incised without danger.

One other point: I am greatly surprised to hear Dr. Grant state that he can lift the peritoneum three inches by an eight-ounce rectal bag. I think experiments have proven pretty clearly that the bladder can be distended with water, and afterward distend the rectum, and it simply

forces the prostate forward, but does not perceptibly increase the space between the fold of the peritoneum and the symphysis.

Dr. Cartledge: It has been my observation that whenever a new operation comes up in surgery everybody is writing upon its technique, etc. After a while it dies down, and all the time it is being subjected to the crucial test of experience and practice, and after a year or two you will find some of the most interesting points concerning it have never been brought up. I think this is notably the case with suprapubic cystotomy. It was largely written upon a year or two ago, but I have hardly seen it mentioned within the last eighteen months. I perfectly agree with almost every thing Dr. Chenoweth has said in reference to the operation. I have myself paid considerable attention to the matter, have done several operations and witnessed others. I do not quite agree with the essayist with reference to the use of the rectal bag. I believe, like Dr. Dugan, that the rectal bag can not raise the peritoneal fold proper more than one quarter of an inch. If this were the case there would be danger of rupture. I have never used the bag, as I never considered it of any service. Further, the rectum is the seat of a plentiful nerve distribution, and I think it was proven several years ago that often very alarming syncope resulted from simple distension of the rectum by the speculum, and I see no reason why any thing that would distend the rectum might not produce the same result. I think this would probably be the most dangerous part of the operation, to tightly distend the rectum, even with a soft rubber bag.

I believe that a free incision should be made over the bladder, and the prevesical fat and peritoneum can be peeled up from the bladder with the fingers until every thing is out of the way. Then the necessary incision can be made in the bladder, removing any growth or stone that may be found. I think the suprapubic operation preferable to the perineal method for impermeable stricture; in fact, in my opinion the perineal operation without a guide is a most dangerous procedure, also as a life-saving measure in the cases of enlarged prostate of the old.

Dr. J. S. Chenoweth: I use Petersen's bag in these operations, because I believe better results can be obtained with it than any other. I recommend the use of the rectal bag to raise the peritoneum, but more especially to raise and steady the base of the bladder, which greatly facilitates operation on this portion. I am sorry there was not more discussion upon the question of drainage, whether the bladder should be fastened to the abdominal wall or dropped back into the pelvis. In

most of the operations I have seen, the custom has been to simply open the bladder, removing the stone or growth, then allowing the bladder to drop back into the cavity of the pelvis. This necessitates the use of a tube for drainage, which is liable to leave a small discharging sinus after the operation. Especially is this the case when the operation is done for cystitis from enlarged prostate, where the obstruction at the bladder neck can not be thoroughly removed.

JAS. S. CHENOWETH, M. D., *Secretary.*

PROCEEDINGS OF THE RICHMOND ACADEMY OF MEDICINE AND SURGERY.

Dr. M. D. Hoge, jr., read the following paper on The Etiology of Cholera :

I propose at the outset to make a few general remarks regarding the morbid appearances after death from cholera, and then enter more into detail regarding the bacillus theory as enunciated by Dr. Robert Koch.

With the exception of the small intestines in which the changes to be described are invariably found, it must not be forgotten that some of the appearances here noted may be entirely absent, for cholera can kill in a very few hours after the onset. *Rigor mortis* sets in quickly, and may last for thirty or even forty hours; emaciation is extreme, the skin is wrinkled and of a ghastly leaden pallor, with cyanosis of the extremities. The eyes are deeply sunken, generally surrounded by bluish-black rings; the nose, chin and malar bones project prominently, and all the features pinched. Decomposition is delayed and the body grows cold slowly.

Many startling and weird descriptions have been given of the strange contractions and twitching of the muscles, which have caused relatives and watchers to believe the corpse returning to life; and where bodies have been exhumed they have been found partly turned on the side, or the legs or arms strangely contracted and contorted, giving the belief that they were buried alive. This may partly account for the elevation of temperature, amounting in some cases to as much as 4° Fahrenheit, after death. The connective tissue, muscles, and peritoneum show a marked dryness, and the intestines are shrunken. The abdominal cavity contains no gas, but in the intestines there is more or less fluid.

The pharynx and esophagus are sometimes normal or show more or less congestion. The stomach is often hyperemic; the mucous coat is covered with a thick, viscid mucus, which is mixed with blood.

The small intestine presents to us the most interesting subject of remark. The mucosa shows at times more or less congestive swelling, and when hyperemia is well marked the membrane is studded with superficial hemorrhages, and in such cases the contents of the intestines are not rice-water in color, but contain a dark, bloody, stinking fluid.

In the more advanced cases the mucous membrane is pale or slightly rose-colored; the extensive epithelial desquamation combined with the immense serous discharge goes to make up the so-called "rice-water discharges," which fluid is found in the small intestines only.

The large intestine is frequently in a collapsed condition, and may present a perfectly normal appearance. Generally, however, the solitary follicles are swollen, hard, opaque, and filled with a sticky fluid.

The mesenteric glands are moderately enlarged, soft and somewhat congested, and filled with a white granular exudation. The spleen, contrary to our usual experience in other diseases, is small and shrunken, with a wrinkled capsule. The liver is rather small, pale brown and anemic. The kidneys, next to the small intestines, show the most marked changes. The tubules undergo cloudy swelling and fatty degeneration. Even where death has occurred in sixteen hours from the time of the attack the kidneys are enlarged, and generally both the medullary and cortical substances are injected. There is a pronounced epithelial proliferation in the urinary tubules, and the cells swollen with albuminoid granules. The bladder is generally empty and covered with a creamy coating of detached epithelium. The ureters, uterus, ovaries, vagina, pericardium and pleura are more or less hyperemic. The heart is firmly contracted and contains very little blood. The inspissation of the blood is generally at its height in about thirty-six hours after the onset of the disease. The proportion of solids is about one and a half times as great as in health, leaving a preponderance of potash and phosphates, with a loss of sodium chloride.

But, aside from the changes just stated, there has never yet been found a characteristic germ in the blood which may be put down as due to cholera alone. The lungs are collapsed and shrunken. The meninges and spinal cord are highly hyperemic.

In commenting on the pathology of cholera the subject will be discussed as to the real and alleged value of the specific bacillus in regard

to its worth for diagnostic purposes and possibly indications for therapeutic measures.

I know the question is one which has caused bitter controversies, both on account of the positive claims made by different observers as to having discovered the bacillus of cholera, and by those who have followed in Koch's footsteps and have defended him. This is to be greatly lamented for the cause of pure science, which aims only after the truth.

For more than forty years it was maintained by Pacini that this was a parasitic disease. As early as 1855 he made notes of autopsies and microscopical examinations of intestinal discharges and erosions of the mucous membranes, which he declared were due to the action of micro-organisms, and were called by him "vibriones," which were always found associated with cholera. So impressed was Prof. Crudelli by these earlier publications of Pacini that, during the epidemic in Palermo in 1866, he established a municipal laundry, to which the soiled linen of cholera patients was carried and placed in vessels containing solutions of chloride of lime and carbolic acid.

It is quite certain that Pacini did not first discover the comma bacillus, his description of the vibriones being very different, and it is well known that the microscopes of that day were not sufficiently perfected to enable him to see the comma-bacillus, though doubtless his researches were of great value to Koch and later investigators.

I remember distinctly the constant undercurrent of excitement in German medical circles in the year 1883 in regard to the various official reports to the government made by Koch from time to time. The professors seldom alluded to them in their lectures, for they were waiting for a final *résumé* of his labors, but it was a constant theme among the students who had then become familiar with his germ theory of tuberculosis. Not till July, 1883, did he make a formal public address, which was delivered before the Berlin cholera conference, and which so soon produced such a widespread interest and discussion.

The main points here presented are from the translations made for the British Medical Journal of that year.

The first question which arose was, Where should the investigation begin; in the blood, or in the contents of the intestines, or in the glands themselves? The blood from some forty or more cholera patients was carefully examined, but nothing characteristic was found. On examining the intestines it was observed that in Peyer's glands there was an invasion of bacteria. Some had partly forced their way into the glands,

some partly pushed between the epithelium, while others went into the deeper tissues.

These had definite size and shape. In addition there were others which, however, appeared to be due to secondary changes, for the bacteria first described always seemed to be ahead of the rest.

In regard to the intestinal contents, at first nothing definite could be isolated, as they were often bloody and putrid and swarmed with all sorts of germs. It was not until a fresh uncomplicated case was examined that the presence of a constant sort of bacteria was found, and then it was observed to be the same as discovered in the mucous membrane.

This particular bacteria Koch called the "comma-bacillus," on account of its peculiar shape. It is about one half as long as the tubercle bacillus, but much bulkier, thicker, and slightly curved. Sometimes they were joined so as to resemble the letters S or C. In artificial cultivations they presented another characteristic: they frequently grew in threads, not straight or simply wavy, but in tender, long spirals. They grow abundantly on fresh Irish potato, meat broth, milk, and gelatine. This latter is a valuable agent both for investigation and diagnosis.

At first, when a test tube containing gelatine is touched with a solution of the comma-bacillus, in a short while the spot looks like a highly refracting granular mass. As they grow the gelatine liquefies immediately in the vicinity of the colony, and the latter at the same time sinks, and a funnel-shaped cavity is formed. This appearance is very peculiar, as it is seen in very few other kinds of bacteria, but never so marked as here; hence this may be regarded as another of the distinguishing marks for the comma-bacillus diagnosis.

They flourish best between the temperatures of 86° and 104° Fahrenheit, and are not killed if frozen at a temperature of 14° Fahrenheit; hence they bear frost very well. They cease to grow on the withdrawal of air and oxygen, but revive if these are restored.

In the artificial cultivations the liquids must contain nourishment enough and not be too acid. All acids do not prevent the growth, for in meat broth there is probably lactic acid and acid phosphate, and here they flourish abundantly. Among some of the articles which arrest the development of the growth may be mentioned alcohol (1 to 10), alum (1 to 100), camphor (1 to 300), carbolic acid (1 to 400), sulphate of copper (1 to 2,500), quinine (1 to 500), and corrosive sublimate (1 to 100,000).

One of the most striking facts in the investigations regarding the retardation of growth and death of the comma-bacillus was that if dried they died absolutely, as was abundantly proved by experiments; wherein again this form differs materially from other bacilli.

In establishing the relation between the comma-bacilli and cholera it was necessary to prove whether they were present in all cases of cholera and absent in all other diseases.

In Egypt ten *post-mortem* examinations were made and examined microscopically; in India eighty-two, and France two. In every instance the comma-bacillus was present, making nearly one hundred cases. More than thirty corpses of patients dying from other diseases of the intestines, such as tropical dysentery, typhoid fever, and bilious typhoid, were examined, but in not one single instance was the comma-bacillus found.

Regarding the relation existing between this bacillus and cholera we may suppose: (1) That the cholera process favors the development of bacilli by preparing a nutritive soil for them to live in. But this presupposes everybody must have these germs in their bodies when the disease attacks them. (2) Owing to the disease, some of the many kinds of bacteria are changed into the comma sort, an occurrence which has never been observed before. (3) And, what is finally true, the comma-bacilli precede the disease and are its cause.

Experiments on animals fed with food on which the bacilli were poured, or even injected into the intestines directly, have never yet produced in them a genuine case of Asiatic cholera. This is not so strange when we remember there are very many diseases which attack man, and which can not be conveyed to animals, and *vice versa*.

Without forced inoculation of human beings there are plenty of instances which answer the purpose just as well, namely, in washer-women. Why should persons who are removed from cholera, and handle and wash the linen containing the vomit and dejections, be attacked, if not from the bacilli contained in them? And such has always been the case.

Besides the facts already stated, the etiology of cholera, so far as known, agrees completely with the peculiarities of the bacilli, and this again is an essential support of the theory that the germs cause cholera.

It has been stated that if bacilli are confined to the intestines, how is it they can cause the death of a person? Bacteria in growing not

only consume material, but produce various kinds of substances. We know a great many of their products have a peculiar nature. Some emit an intense smell, others a coloring matter, and others poisonous substances, and to this latter class must be reckoned the deadly effects of the comma-bacillus.

The practical question now arises, If the comma-bacillus is the cause of cholera, are we any better off regarding our knowledge of treatment of this disease? The answer to this is, that in the main we are. It is of the utmost importance to know whether or not we have a genuine case of cholera to deal with to prevent its spreading from that focus and adopt proper sanitary measures. The chances of success are very largely in our favor in the first stages of the disease; and finally, having found the cause, we will all have fixed and definite lines to work upon in the future.

It is useless to enumerate a long list of names of more or less eminent bacteriologists who have investigated this question. Koch's opponents have invariably sought to disprove his theories rather than come to his convictions by candor. In considering the various claims to the correctness of their conclusions we must bear in mind the experience and expertness of this class of work and the methods of investigations. The isolation and discovery of the comma-bacillus is difficult, and many of the discrepancies may be due to an unfamiliarity with the necessary scientific technique. If Koch has done nothing else, he has pointed out the path in which future inquirers should go.

In conclusion, I will show you a slide containing the comma-bacillus which was imported from Koch's Berlin Institute.

Mr. Hugh Blair continued this subject by speaking of *The Value and Sphere of the Various Disinfectants and Antiseptics in Cholera*. "The science of bacteriology is the father of the science of disinfection." During fifty or one hundred years thoughtful and able physicians in Europe, pondering measles, smallpox, scarlet fever, and typhus, discerned a semblance to a sort of fermentation set up by some ferment that gained access to the blood, and the term zymotic disease (zumoô, to ferment) obtained a place in the medical vocabulary. Leibig, the great chemist of his day, expounded fermentation as a phenomenon begun and continued by dead or decaying matter undergoing dissolution of its atoms, and setting up by means of catalysis certain chemical reaction among the atoms of other organic bodies, thus forming new compounds.

Pasteur dissented from Leibig, and proved by experiment that fermentation had for its origin a living germ, a plant, and that fermentation was but the life history of that plant, its food, its growth, and its work; that sugar could only be made into alcohol and carbonic acid by means of fermentation, and that fermentation was the work only of a living plant, *Saccharomyces cerevisiæ*, and furthermore that life only could produce life. Pasteur's account of fermentation is universally accepted by science.

In the process of fermentation we see an explanation of the cause of disease, the ferment (one of the bacteria) rapidly reproducing itself, the work of the bacteria, a ptomaine, a poison, sometimes of the kind that prostrates the vaso-motor system, sometimes that ulcerates the intestines, sometimes that impoverishes the blood beyond its ability for physiological use, sometimes producing skin eruptions, and sometimes robbing the blood of its life.

This is not an illustration, but fact; fact substantiated not only by analogy, but by the senses, for the microscope has revealed the bacteria to the eye, and chemistry has separated the poison, the ptomaine. The various bacteria have been sown like seed in suitable soil, and the same plant that was sown has been reproduced. By experiments on living animals it has been proved that these bacteria are the etiological factors in disease, the one of the one kind and another of another. Bacteria are not a consequence, but a cause of disease, and when the body, so curiously and wonderfully made, succumbs to their power they proceed to take it down atom by atom till all that was visible disappears.

"Pasteur has shown that all bacteria develop from pre-existing bacteria or the spores of the same. They can not arise *de novo*."

In 1883 Koch with others was sent by the German Government to India to investigate cholera. Koch discovered in the intestinal contents of cholera patients the cholera bacillus, and by experiment proved it to be the originator of cholera.

In order to prove that any microbe is the etiological factor in disease it must comply with Koch's four rules:

1. It must be found in the tissues or secretions of the animal suffering from or dead with the disease.
2. It must be cultivated outside of the body on artificial media.
3. A culture so obtained must produce the disease in question when it is introduced into the body of a healthy animal.
4. The same germ must again be found in the animal so inoculated.

Can cause and effect require any further proof?

The cholera bacillus is about half the size of the tubercle bacillus. Grouped, they appear as spirals. They have no spores. Spores have an envelop which has great powers of resistance to outside treatment, and therefore are not easily destroyed. It requires a temperature of 300° to destroy some spores. Comma-bacilli are easily affected by heat and exsiccation.

At ordinary temperature the cholera bacilli develop on media that have an alkaline or neutral reaction. They can live in the presence of air, but better without air.

The cholera bacilli communicate disease only by their presence in the alimentary canal. "We eat and drink cholera, but we do not breathe cholera."

Acids are found to be inimical or destructive to the life of the cholera bacilli. For this reason it is supposed that before they take effect they must in some way find entrance to that part of the alimentary canal where the fluids are alkaline. The fluids of the stomach, if in their normal condition of acidity, ought to be an impassable barrier to the bacilli, but the comma-bacillus is not entirely inactive in an acid fluid.

Bacteria feeding upon organic compounds produce chemical changes in them, not only by withdrawal of certain elements, but also by the excretions, ptomaines. "A ptomaine may be defined," say Vaughn and Novy, "as a chemical compound which is basic in character, and which is formed by the action of bacteria on organic matter. On account of their basic properties, in which they resemble vegetable alkaloids, ptomaines may be called putrefactive alkaloids."

The terrible phenomena of cholera can only be accounted for by the action of a dreadful poison, a ptomaine, and this ptomaine can only be accounted for by the presence of the comma-bacillus. The comma-bacillus has been cultivated on suitable soil, gelatine, etc., and the ptomaine has been separated and administered to animals with deadly effect.

In what has now been said we have endeavored to give an account of cholera as a germ disease, as it is put forth at this time by science. It is hardly necessary to mention the distinguished names that are responsible for this teaching. A great many hours would be necessary to detail the experiments they have made. Learning, ingenuity, and patience have been at work, and they have come to this conclusion, that the comma-bacillus and its ptomaine or ptomaines are the only infection that produces Asiatic cholera.

The question before the Academy is this: "What is the value and sphere of the various disinfectants and antiseptics in cholera?"

The words "antiseptic" and "disinfectant" are often confounded with each other. The antiseptic—*anti*, against, and *septos*, putridity—has nothing to do with this subject. A disinfectant is simply an agent that has the power of destroying infectious material.

The infectious material of cholera is found in the alvine discharges and in vomited matter of the patient. It is not found in the blood. In cholera the blood is said to be acid. The comma-bacillus will live in water contaminated with organic matter; also in milk.

Dr. Sternberg insists that a pure water supply is altogether necessary in preventing an epidemic of cholera. Cholera patients were carried from Naples to Rome, with its abundant supply of pure water, and from Hamburg to Berlin, and no epidemic ensued.

Cholera is communicated in any way that the bacillus is transported. Soiled clothes, soiled bedding of the cholera patient, contaminated water, milk, or other food that has come in contact with the bacillus will convey the poison.

The sphere, and the only sphere of disinfectants, is to destroy the vitality of the comma-bacillus. The ptomaine can hardly be attacked with disinfectants. It delivers its blow, and the effects are to be counteracted with constitutional remedies. All clothing, utensils, cess-pools, drains, and every thing else associated with the disease should be disinfected at once. Heat, dessication, sulphurous acid, carbolic acid, chlorine, corrosive sublimate, all may be used.

Koch found that sulphurous acid would not kill spores, but no spirillum has spores. Dr. Raymond, of Brooklyn, quotes the Odyssey anent the ancient use of sulphur as a disinfectant:

"Fetch me brimstone, sweetener of taints, and fetch me fire, old woman, that I may fumigate the hall; and straight she fetched him fire and brimstone; and Odysseus right thoroughly fumigated everywhere—the common hall, men's room, and all the courts."

Dr. Sternberg suggests the use of recently slaked lime, as used in the last Italian epidemic. He says the spirillum of cholera and various other organisms found in the dejecta of cholera are destroyed by a freshly prepared milk of lime. And recently slaked lime thrown into cess-pools and vaults is one of the best means of disinfecting excreta in the mass. Sulphate of iron is only a deodorizer.

The comma-bacillus has been found in the dejecta of patients five

or seven days after the beginning of the attack; so it is necessary to apply internal remedies to destroy its vitality. But after the bacillus has manufactured the ptomaine it is too late to talk about internal disinfection. At this juncture the question is, What will counteract the ptomaine—the powerful poison whose manifest and fatal office is to set up an exosmosis by which the serum of the blood is diverted out of its natural channels into and out of the alimentary canal?

At the same time it is well to remember that small quantities of muriatic and nitric acid destroy the life of the cholera bacillus in culture experiments, and it follows that these acids and other such acids might be used by the community at large with their daily food in such a manner as to prevent an epidemic of cholera.

The sphere of disinfectants in cholera, as we have said, is to destroy the vitality of the comma-bacillus and to sterilize what might be called its habitat. The value of disinfectants in cholera is expressed in the current phase, "An ounce of prevention is worth a pound of cure."

History says that Hippocrates stopped the plague in Athens by burning the boughs of incense-bearing trees in the streets, and for this he obtained the gift of a crown of gold. From that time to this disinfectants have been used empirically. Now they are used scientifically. All spores and all bacteria can not be destroyed by the same disinfectant. Experiment must decide what is favorable to the life of the germ and what is destructive to it. If we can destroy the seed the harvest will be prevented. More light is wanted and more light is coming, and it is to be expected that disinfectants will in time be used with the same effect in mitigating and preventing epidemics that water is used in quenching a conflagration.

DISCUSSION ON CHOLERA.

Dr. J. S. Wellford: The unqualified acceptance of the theory that refers the causation of disease to micro-organisms has done incalculable harm. The germ, considered as an etiological factor, has been pampered to too great a preponderance in the mind of the modern pathologist. It is more probably a scavenger than a disease-producer. Though we find the tumble-bug in a pile of dung, it does not follow that the bug produces the dung. On the contrary, it is there because the dung is a favorite habitat for the bug. And so, instead of the disease being a result of the germ, may not its pathological products furnish an environment so favorable to the life and growth of the germ that it sedu-

lously seeks the diseased structure, multiplying and flourishing on the devitalized tissues?

Such being the case then, the germ may be of material interest and aid to the diagnostician. With a knowledge of the invariable selection of tissues the subject of definite disease by certain germs, the presence or absence of the appropriate germ in a given case would aid us materially in diagnosis.

The only culture fluids in which bacilli will thrive are those that will produce a ptomaine. The ptomaine is more likely the cause of the disease than the bacilli. Tyrotoxon, a ptomaine, may be separated from milk, and when administered produce all the symptoms of cholera infantum. Cadaverin, the ptomaine generated by retained fecal matter, being absorbed into the circulation, is responsible for the systematic disorders of constipation. It is the absorption of the poisonous ptomaine, not the presence of the bacillus, that causes the disease.

Mr. Hugh Blair: The ptomaine bears the same relation to the bacillus that the honey does to the bee. Without the bacillus we could have no ptomaine, and therefore no disease that results from the absorption of the ptomaine. The destruction of the bacillus puts an end to the production of the ptomaine.

Dr. Wellford: The treatment of so-called germ diseases by destroying the germs with germicides and antiseptics has signally failed to give the good results that would logically follow if the claims of the germ theorists are tenable. This has been notably illustrated in the present cholera epidemic in Germany, where the antiseptic treatment has been abandoned for calomel, which a recent letter from Hamburg declares to be the "sovereign remedy."

Dr. J. Michaux: Is not calomel an antiseptic?

Dr. Wellford: Stimulating the glandular system to a proper performance of its physiological functions and having a general therapeutic activity, it is something more than an antiseptic, and its efficiency in such cases is due to the former influences. The experience of German physicians in the present cholera epidemic favors the employment of subcutaneous injections of saline solutions, and the use of hot baths when the temperature becomes sub-normal. The opium treatment has been abandoned, though morphine is used to quiet the pains.

Dr. W. S. Gordon: Are the bacilli separated from the ptomaine when it is attempted to inoculate the guinea-pig with tuberculosis? I have seen it stated that the culture containing the comma-bacillus may be so

heated as to destroy the vitality of the bacillus and yet produce Asiatic cholera upon inoculation.

Dr. M. D. Hoge, jr.: Prof. Koch seems to deny the possibility of this when he states that the dried bacillus will not produce cholera. It is for this reason that it is maintained that the contagium of cholera is not found floating in the atmosphere.

Dr. John N. Upshur: What is the earliest stage of consumption in which the bacillus tuberculosis can be discovered?

Dr. Hoge: I do not know. But in the recent epidemic of *la grippe* in this city I examined the spudor of five patients for Dr. Landon B. Edwards, who was in doubt as to a diagnosis. I found the bacillus tuberculosis in each case, and all five have subsequently died with consumption.

Dr. Wellford: Pettenkofer took the dejections from a cholera patient and gave a part immediately to some mice, none of which showed signs of cholera. A portion of the same dejections were kept five days and then given to other mice, and they all had cholera. When ten days old the feces ceased to produce cholera. The inference is that the ptomaine formed subsequent to defecation reproduced the disease.

Mr. Blair: Koch has produced cholera in animals by arresting the peristalsis of the bowels with opium, and rendering the contents of the stomach alkaline. The acidity of the gastric secretions militates against infection. Disease is not caused by an influence, but by an entity. There can be no ptomaine without a bacillus; and by keeping out or killing the bacillus we preclude the possibility of a ptomaine. Calomel is one of the best germicides, and to this fact must largely be ascribed its usefulness in the treatment of cholera.

Dr. Upshur: I admit the presence of organisms in disease, but question their causative relation thereto.

Dr. Wellford: *Torula cerevisiæ* makes alcohol, but no one will fail to admit that it is the alcohol that intoxicates, and not the *Torula cerevisiæ*. Similarly the bacillus makes the ptomaine, but it is the ptomaine, and not the bacillus, that causes the disease. Parvin states that puerperal fever may follow contagion from diphtheria, scarlet fever, measles, etc., which goes to prove that it is due to a contagious material, and not to a definite entity.

JAMES N. ELLIS, M. D., *Reporter.*

Reviews and Bibliography.

A Manual of Physics, being an Introduction to the Study of Physical Science. Designed for the Use of University Students. By WILLIAM PREDDIE, D. Sc., F. R. S. E., Assistant to the Professor of Natural Philosophy in the University of Edinburgh. 501 pp. New York: G. P. Putnam's Sons. London: Bailliere, Tyndall & Co. 1892.

One by one the plans underlying physical processes have been elucidated and placed upon a basis of mathematical demonstration, until now the calculus bids fair to cover in the whole of natural phenomena. Indeed a phenomenon, as a prerequisite to admission into the category of pure physics, is now required to stand the test of mathematical examination.

In a higher order than in any previous text-book the author of this volume has brought into prominence the necessity for and the value of scientific hypothesis. While the aim has been to make the mathematic treatment as simple as possible, the author has not found it practicable to dispense in a large measure with the elementary methods of the calculus. Coming from the schools wherein Thompson and Tait and Clerk-Maxwell have left the impress of their genius and profound study, it is not reasonable to suppose that it is among the books to be selected for light and leisure reading.

Its demonstrations, as indeed is the case with all true mathematical demonstrations, are above criticism, and it is only the accuracy or efficiency of assumptions that can be questioned, and the opportunities for this at the hands of a mere tyro in physics are rare enough indeed. However, a few such present themselves, and inquiry may be made as to whether the purely mathematical demonstration of equilibrium and surface tension in fluids might not be supplemented to advantage with a more practical illustration of underlying principles. It hardly seems sufficient to demonstrate that pressure at a given distance from the center of fluid mass is necessarily the same, whatever the magnitude of the mass may be, when such fluid is left free to obey the force of cohesion or gravitation. That would account for the fluid remaining level after that state is gained; but if it is not level, by what definite physical steps or processes does it become level? So with the spherical form assumed by free fluids. It is easy to demonstrate that the state of equilibrium is found in the sphere; that a soap-bubble, for instance, will retain the spherical form because any other shape would diminish the capacity of the containing film; but how could the flattened soap-bubble become spherical? We should be disposed, for our part, to claim that it is due to the operation of the potential wedges into which every mass of fluid may be assumed to be divided. When the particles of a fluid are forced toward a common center, whether by the attraction of cohesion, by the kindred force of gravitation, or by strain due to the pressure

of an inclosing sac or film, if the wedges into which it may be divided, and having their bases at the circumference and their apices at the center, are of unequal length, the long and acute ones will advance and force back the short and obtuse ones until all are of equal length and the mass becomes a sphere.

The credit of the discovery of the nature of heat as being a mode of motion is given as usual to Rumford and Davy, yet it is worthy to be considered whether Sir Francis Bacon, among many crude suggestions, did not give out enough to set men to thinking on this subject. At the close of one of his essays he asks, what is the difference between the movements of the body and the heat it contains, except that the latter is the motion of smaller particles of matter, a sentence that would not be out of place in this crowning example of text-books on physics at the close of the nineteenth century.

The reviewer has sought diligently for proof of a view long held that light is retarded in its progress through space, but fails to find it in the explicit form desired. The author does show, however, that of the many millions of vibrations that light gives per second, no more than two hundred thousand of these have been proved to be practically similar, and that it is therefore possible that the nature of the vibrations may have completely altered in the interval of time between the setting out from the source and the arrival at the point of examination. It is some comfort even to have thus much support for a conclusion reached through a consideration of the behavior of earthquake and of ocean waves, and the apparent constitution of the more tender feelings of the human mind.

The author perpetuates what seems to the writer a fallacy in the theory of Laplace in his "Mechanique Celeste," that a ring of matter left separate by a contracting globe would take on rotation in the same direction as the primary mass, although such ring should be contracting in the direction of the center of the primary. With this doctrine we feel compelled to take issue. If a mass were to be thrown off from the earth at a tangent it would rotate in the same direction as the earth, for the reason that the angular motion of the outside of the mass would bear an increasing ratio to the angular motion of the inside with the increase of the distance from the center of the earth. On the other hand, if a mass could fall inside of the earth's surface it would rotate in the opposite direction to that of the earth.

On the whole, the book is a superior one, but not likely to be introduced into our medical schools during the two years' course, nor even after the term has been much extended.

D. T. S.

FAMINE IN RUSSIA.—In the province of Tula the distress is worse than it was a year ago, on account of the failure of the crops. Typhus fever has again appeared to an alarming extent.—*Boston Medical and Surgical Journal*.

Abstracts and Selections.

THE NERVOUS ORIGIN OF JAUNDICE.—At a recent meeting of the Massachusetts State Medical Society Dr. A. D. Rockwell read a paper on this subject. He said it is a well-known fact that disturbance of the brain, both organic and functional, may very seriously interfere with the functional activity of distant organs. A cerebral disturbance may be the direct causative factor of very persistent derangements of the sexual apparatus. The bladder, intestines, stomach, and heart may also be disordered by diseases of the central nervous system as well as the kidney and the liver. So closely and so strangely are the vascular and the general nervous systems related to each other that their pathological conditions are often inseparably connected. The nervous system has an alliance so close with the functional activity of the secretory and excretory glands of the body that emotional disturbances, according to their character, act as depressants or excitants of the functional life of these organs. Some of the more common of these effects are every day familiar facts, as when the flow of tears is excited through grief, or the secretion of saliva and gastric juice through the smell of food. In the same manner as the superficial glands are easily influenced, so in all probability are the blood-making or ductless glands regulated and controlled by the organic nervous system. Dr. Murchison, to whom the world is so much indebted for enlightenment on this subject, asserted that not only was the secretion of bile interfered with by prolonged mental anxiety, worry, and incessant mental exertion, but that the principles of sanguification and blood change, in which the liver takes part, were frequently deranged from these same causes. He states that acute atrophy, in which the secreting cells are rapidly disintegrated, and the functions of the organ arrested, appears in many instances to have a purely nervous origin, and very often the first symptoms of the disease have occurred immediately after a severe fright or an outburst of passion in a person previously healthy. An impression made upon the brain appears to be reflected to the liver and deranges its nutrition. Even cancer of the liver appears sometimes to result from the functional derangement induced in the first instance by mental trouble.—*Boston Medical and Surgical Journal*.

HYOSCYAMUS AND ATROPINE POISONING.—Rudolph (*Centralbl. f. Klin. Med.*, October 8, 1892) reports four cases of henbane and one of atropine poisoning. The former occurred in four brothers, aged eleven, nine, seven, and five years respectively, who had eaten the seed capsules. Symptoms common to all four were red face, dilated pupils, dry lips and mouth, restlessness and mental excitement. In one case the symptoms were but

slightly marked. In the boy aged five there was a period of marked apathy preceding the excitement. In only one case was there a rise of temperature (38.3°C.); and in another case there was a scarlatiniform eruption on the thorax, and especially on the buttocks. In no case was the pulse more than 110. In two days' time all the boys were discharged well, but with dilated pupils. The treatment consisted in washing out the stomach and the subcutaneous injection of morphine. The case of atropine poisoning occurred in a woman aged thirty. She was brought in by the police, who thought her insane. She was rambling, and her gait was uncertain. The face was red, the pupils widely dilated, the lips and mouth dry, the pulse 132, and the temperature normal. The feces and urine were passed unconsciously. The stomach was emptied, and atropine found in the contents. Morphine was injected. In twenty-four hours her mind was clear, and she was discharged well on the following day. The symptoms of atropine and hyoscyamus poisoning are almost alike. The mental condition is one of excitement, combined in henbane poisoning with hallucinations. These hallucinations may be absent in atropine poisoning. The tendency to sleep in the former condition was not noted at the beginning of any of the cases, but the deep coma in the boy aged nine the author would attribute to the action of the poison, and not to the small dose of morphine given. In this condition the pupils, as in ordinary sleep, were minutely contracted. Morphine is a very useful remedy to overcome the mental excitement, but it should not be given in too small doses.—*British Medical Journal*.

SUBCUTANEOUS INJECTIONS OF PHOSPHATE OF SODA IN NERVOUS AFFECTIONS.—Crocq (*Gaz. Méd. de Liège*, October 20) has tried subcutaneous injections of phosphate of soda (2 grams in 100 grams of laurel water) in nervous diseases. Three cubic centimeters of this solution were injected under the skin of the arm or leg with strict antiseptic precautions, at first every day and afterward on alternate days. No reaction, local or general, followed. Only a slight feeling of heat at the seat of injection was complained of, but this disappeared in a few minutes. The author states that the drug, used in the manner described, is a powerful nerve tonic, which will effect a cure in cases of functional disorder, but can only have a palliative action where organic lesions of nerve centers are present. He recommends the method as equal in efficacy and much superior in simplicity to the injection of testicle juice, as practiced by Brown-Séquard, or "nervous transfusion," as recommended by Constantin Paul. (See *Építome*, March 19, 1892, par. 254.) He relates several cases (locomotor ataxy, etc.) in which the injections of phosphate of soda were followed by highly satisfactory results.—*Ibid*.

THE New York Medical Journal states that Prof. Hobart A. Hare, of Philadelphia, has, at the request of the Nizam of Hyderabad, undertaken a new research on the action of chloroform.

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"NEC TENUI PENNÂ."

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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CHOLERA IN THE SPRING?

In view of the unexampled provisions made and making in this country for the entertainment of the inhabitants of the earth at our coming Columbian Exposition, the cholera outlook is just now the most important question in American affairs.

It can not be disputed that our people are alive to the importance of the situation, and that wonders may be looked for in quarantine restrictions upon the coast and in the general sanitary awakening of the interior; but, nevertheless, the outlook is gruesome, since cholera still has a foothold in Europe, with every prospect of fresh outbreaks when the weather shall again grow warm.

Our authorities may keep the disease out of America; but no assurance of safety will be likely to tempt the timid foreign tourist to leave home if cholera be rampant in Europe at the time of his intended departure.

The British Medical Journal, of December 24th, gives the following condensed statement of what cholera is doing in the districts where it ran riot last summer. The report is interesting as an example of what cholera can do in cold weather, if it be not darkly prophetic of trouble in the spring and summer:

RUSSIA.—Cholera continues in St. Petersburg, although the deaths are only at the average rate of little more than one a day; thus on December 10th there were 4 cases and 1 death; 11th, 3 cases, 1 death, and 35 cases in

hospital; 12th, 8 cases, 1 death; 13th, 3 cases and no fatalities; and 14th, 2 cases and 3 deaths, 12 recoveries being chronicled against the 6 deaths during these five days. The Russian ports on the Black Sea and Sea of Azof have been officially declared free, but cholera is still virulent in the southwestern Government districts. An official return of the cholera epidemic of 1892 in Russia, compiled to the end of November, states that in the European provinces there were 289,961 cases and 132,786 deaths; and in Asiatic Russia 261,411 cases and 134,502 deaths, yielding grand totals of 551,372 cases and 267,288 deaths in the whole empire. The mortality among persons attacked was over 48 per cent. The provinces showing the largest death returns were Saratoff, with 21,033 deaths; Don Cossack Territory, 18,207 deaths; Samara, 18,040; Kuban, 15,045; Tursk, 13,112; Tobolsk, 12,729; Voronesh, 12,072; Astrakhan, 10,980; and Daghestan, 10,457 deaths—a total of 131,675 deaths in these nine districts, or nearly half the mortality of the empire. In the town population, 51,853 cases occurred, with 26,172 deaths, a mortality rate of over 50 per cent. Over thirty provinces were still returning cholera cases at the close of last month in European Russia.

GERMANY.—Four cases of cholera occurred at Hamburg and Altona between December 12th and 14th. One death took place on the first-mentioned date, and 2 cases are reported from the same house on December 16th. One case also occurred on December 18th. Some of these seem to have originated in the city itself, and 1 in a suburb of Hamburg. The city board of health has now, we understand, made every preparation for dealing with any fresh appearance of cholera next year.

FRANCE.—One death from cholera was registered in Dunkirk on December 15th, and we learn that deaths, at the rate of some half-dozen, were of daily occurrence at L'Orient during the first fortnight of the present month.

HOLLAND.—Only 2 deaths were heard of in Holland during the week ended December 10, 1892, 1 being at Capelle, and 1 in Yssel in South Holland.

AUSTRIA-HUNGARY.—After a freedom from cholera of many days, Buda-Pesth had 2 fresh cases and 1 death notified on December 17th. Cholera is stated to have broken out in the garrison of the fortress of Petervardein in South Hungary quite recently.

TURKEY.—Cholera is still present in Turkey, in the little town of Yan. In Yemen several choleraic deaths have been reported from Setif, an Arab village, situated opposite the island of Camaran. During their quarantine on this island the Turkish troops lost more than 100 soldiers and several guards from cholera.

The same journal, in its issue of January 7th, gives the following statement of the situation. It does not augur well for the coming summer;

RUSSIA.—The cholera would seem to be dying out at St. Petersburg, where recently on several days there have been no fresh cases. In the week ended December 24th there were only 10 cases notified, with 6 deaths, and on the date in question there were but 10 cases under treatment in hospital. The disease appears to be still spreading in Russian Poland.

GERMANY.—So far as we can learn, there were 36 cases and 16 deaths from the disease in Hamburg during last week, of which 30 cases occurred in four days; 6 deaths took place on December 30th, 1892. In Altona 2 deaths took place on December 29th, and 5 on the succeeding day; and 2 in Wandsbeck. The harbor district of Hamburg does not seem to have suffered.

FRANCE.—At Dunkirk between December 27th and December 30th, 1892, 15 cases and 8 deaths were reported. The disease appeared in the neighboring village of St. Pol at the beginning of the present week, while we learn of the "continued spread" of cholera at Grand Fort Philippe, near Gravelines, where 13 deaths took place on December 27th, although we can not find previous mention of the malady at that place. Three other deaths were reported on December 29th. Calais and Boulogne have had a few scattered cases during the latter half of December, but it is thought that many more cases are occurring in the northern districts of France than are publicly announced. There were upward of a dozen deaths at L'Orient alone during the last week of 1892.

ENGLAND.—The Sanitary Committee of the Town Council of Southampton, in view of a probable outbreak of cholera in the spring, have decided to purchase a vessel, to be used as a floating cholera hospital, and cases on board ship and in the town will be transferred to this vessel and there treated.

While we have no desire to play the alarmist's rôle, we can not shut our eyes to the facts in the case and their doleful augury, and in view of the outlook it is to be expected that no physician in town or country will come short of his full duty in the case.

HISTOLOGY OF PSORIASIS.—Schutz infers (*Archiv. f. Derm. und Syph.*, 1892, 5 Heft) from his studies of the histology of psoriasis that in this disease there is unusual development of elastic fibers. He found in sections from psoriatic skin that these fibers were larger and more numerous than in any sections of the skin which he had previously seen. He could trace without difficulty minute elastic fibers from the papillæ into the rete mucosum as far as the second or third layer of cells. In normal skin the same relation of elastic fibers to the cells of the rete could be observed, but with much more difficulty, and fewer fibers were visible.—*British Med. Journal.*

Notes and Queries.

POISONINGS BY "INFANT'S CORDIAL."—The frequent occurrence of the fatal poisoning of infants in consequence of the incautious use of narcotic preparations known as soothing syrups, infant's cordials, etc., is one among many proofs of the need for a more stringent administration of the law relating to the sale of poisons. Three cases of this kind have recently been the subject of inquiry before coroners at Leeds, Stourbridge, and Oldham. As is commonly the practice, the verdict of "death from misadventure" was accompanied by a recommendation from the jury that measures should be taken to prevent the promiscuous sale of such dangerous compounds by unqualified persons. But unfortunately it is seldom that any thing further is heard of these recommendations, and the mischievous trade goes on unchecked. However, in the Stourbridge case, the coroner stated that he would represent the matter to the proper authorities, and we trust that it may receive from them the attention it demands. The evidence in the Oldham case showed that the cordial was sold without a poison label, and by an unqualified person. There is no doubt that this is very generally done, and though these preparations are administered to children by ignorant persons without ill intention, their use is attended with great danger, while the sale of them exposes the vendors to serious risk. In this case the coroner pointed out that if the death of the child had been conclusively proved to be due to narcotic poisoning, both the seller and the maker of the "infant's cordial" might have found themselves in a very awkward position. But the most serious feature of this case was the statement of the maker of the "cordial" that it did not contain opium or any thing of that kind. Upon analysis, however, morphine was found in it, and the attempt to mislead the court was justly stigmatized by the coroner as a disgraceful attempt to conceal the twofold breach of the law which had been committed by the unqualified vendor of the "cordial" and the maker of it, who supplied it without being properly labeled "poison." The coroner's censure of the whole proceeding should be a warning to persons who have been in the habit of selling these dangerous preparations, and it is to be hoped that his declared intention of taking immediate steps to bring the matter under the notice of the Pharmaceutical Society will have the effect of inducing that body to take further proceedings against the offenders in this case.—*British Medical Journal*.

THE IMMIGRATION QUESTION.—The Joint Committee of Congress on Immigration has been unable to agree upon a bill, and has decided to report two bills, one to the House and the other to the Senate. That reported to the House provides for a quarantine abroad and for suspension of immigra-

tion whenever the President deems it necessary for the prevention of the introduction of any contagious disease into the United States. The Senate bill suspends all immigration for one year. The opposition to limiting immigration appears to have come largely from the South and Southwest, where labor is in demand. The experience of past years, however, shows that for some reason immigrants do not go to that part of the country, and it is therefore hard to understand the opposition. Both branches of the Vermont Legislature have passed a resolution that it is for the interest of all States to pass a law restricting the immigration of paupers and criminals. The resolve is sent to each executive department in the various States and to Congress. The executives of the different States are requested to send the matter to the legislatures.—*Boston Medical and Surgical Journal*.

CHOLERA IN HAMBURG.—On December 20th two fresh cases of cholera were reported, and in the next week from thirty to forty more. This outbreak has produced a feeling of depression in the city, although the authorities make light of it. The water supply is not yet satisfactory, and the city authorities have been criticised for their tardiness in getting the city into good sanitary condition.—*Ibid*.

Special Notices.

VOMITING IN CHOLERA.—The following mixture has been recommended by Laussedat as of great value in combating the vomiting of cholera (*Therapeutic Gazette*):

Ethereal tincture of valerian, ℥lxxv;
 Sydenham's laudanum, ℥xv;
 Essence of peppermint, ℥v;
 Hoffman's anodyne, ℥lxxv.

Sig: Twenty-five drops of this mixture is to be taken every few minutes until the tendency to vomit is relieved.

V. R. PERKINS, M. D., Mercer, Me., says: I have tried your CELERINA to perfection, and find it one of the best articles I have ever used in my practice as a nerve tonic. I have used it in a very large number of cases of nervous headache, neuralgia, and in one case of paralysis where all other nerve tonics failed; also in hysteria I often use it with success, and also in all languid and debilitated conditions of the system. It works like a charm in dissipations of all sorts, and some of nerve power arising from venereal diseases. Really I can not do without it in my extensive practice. I have used it in ten cases of dyspepsia without fail. It also has no equal on persons who lead a sedentary life. It is perfectly safe to give to the oldest person, however weak, or the smallest child.

GONORRHEA:

R S. H. Kennedy's Extract Pinus Canadensis, 2 oz.;
 Glycerine, 1 oz.;
 Port wine, 2 oz.;
 Hydrastia sulph., 4 gr.;
 Aquæ destil., 2 oz.

THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNÆ."

VOL. XV.

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No. 3.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

SOME NOTES ON THE STUDY OF OPHTHALMOLOGY.

BY J. G. CARPENTER, M. D.

Being on a sojourn in Philadelphia, it has occurred to me to contribute a few clinical notes taken in the study of ophthalmology in this place, and especially in connection with the Polyclinic Hospital and at Wills' Hospital. There are many other hospitals here, a few of which will be mentioned, viz., the Children's, St. Christopher's, Blockley, Jefferson Medical College Hospital, Orthopedic, Methodist Hospital, to which ophthalmic students can go, but the student who uses his time well at the Wills' and Polyclinic Hospitals with the proper amount of study will have little time to attend the other hospitals. The hospital staff of the Polyclinic, as teachers and operators and clinicians, may have their equals, but certainly no superiors.

SURGICAL CLINIC OF DR. RISLEY, WILLS' HOSPITAL.—Mr. X, age eighty-three years, general health good, has blindness of left eye due to cataract, pupil dilates rather imperfectly under atropine, iris dense, inelastic, and this case most surely is not one for simple extraction. The cataract extraction was done with iridectomy, and it is thought here by the ophthalmic staff that such cases should be preceded or accompanied by iridectomy, and that the safest extraction of all methods, both to patient and operator, is that with preliminary iridectomy. This view is confirmed by Landolt and his eminent *confrères*. After extraction the cornea was umbilicated, but regained its normal *situs*. After thorough cleansing with one-half-per-cent solution of chloride of

sodium in distilled water from a dropping tube and nice coaptation of lips of wounds, the dressing was applied, viz., eserine gr. $\frac{1}{4}$ to aqua \mathfrak{z} j, one drop instilled into the eye one or more times per day, the lids gently closed, then isinglass strips applied to lids of both eyes, aseptic absorbent cotton and Liebreich's bandage; adjusted over this a wire-woven protector to keep patient from interfering with the dressing or injuring the eye. Forty-eight hours after operation eye looks a little red; slight ciliary injection. Atropine drops are substituted for the eserine, and patient's eye dressed as formerly described.

CASE 2. A complicated cataract following choroiditis in a man about fifty years old, the arcus senilis prominent and well marked, shallow anterior chamber, cornea quite small, lens seems quite large. On account of the small size of the cornea a large area of the periphery was included in the linear incision. The Graefe knife was used, which is the favorite cataract knife here, and extraction was done with iridectomy. Capsule tough, incised with knife, the lens dislocated in capsule and with complete rotation, and finally after some delay was removed in the capsule. A most wonderful feat was this, extracting the capsule with lens inclosed. When the lips of wound were coaptated after thorough cleansing and asepsis patient could see fingers, also Prof. Risley's watch, and with a strong plus lens told the time, 3:20 P. M. Technique of after-dressing similar to that described in first case, except the omission of eserine.

CASE 4. Male, age forty-five years, several years since became blind in upper half of the field, detachment of retina in lower field with vitreous opacities. In a year from this period the lens became cataractous, which latter is quite liable to follow detachment of retina. A preliminary iridectomy was done before the extraction of the cataract. There was no inflammatory reaction to follow either the iridectomy or extraction. Eventually the pupil became filled with a grayish substance, except at the upper margin, where there was a pin-hole pupil and much displaced. Anterior chamber was separated from the posterior, and was quite shallow. The iris is dragged up, distorted and fan-shaped, with handle of fan above at pin-point pupil. Tension is greatly increased, eye glaucomatous. An iridectomy is done by Prof. Risley horizontally with a Graefe knife, the edge and point turned toward the iris after entering the anterior chamber. Iris is very tense, difficult to incise. A horizontal pupil is made by separation of the tense vertical iris fibers. Anterior chamber and circulation between it

and posterior chamber restored. Patient sees light. Tension gone at once after the iridectomy. Dressing and technique aseptic, and similar to that narrated in other cases. Patient has complained of feather-shaped photopsia. Half or full circles move from below upward, then divide, roll out; sometimes one rolls in, the other out, or roll around the eye, and are of a golden color.

A most interesting case was one of skin grafting of the upper lid, forehead, and side of face to get rid of contractions following a burn, with most beautiful and remarkable results, again showing another triumph in surgery, giving the patient quite a presentable appearance. Several cases of former trachomata show the curative effect of rolling the lids with Knapp roller forceps, and how much the treatment of granular lids is hastened by rolling and compression. Most gratifying results have been obtained in treating acute and subacute dacryo-cystitis, and purulent inflammation of lachrymal sac with incision, antiseptic irrigation, drainage, aseptis, and hot fomentations.

The week in ophthalmology was a great success. Progressive ophthalmologists know the value of contact with their *confrères*. Special journals and special societies are good, but many points are acquired only by watching the actual clinical work of fellow practitioners. To afford those engaged in ophthalmic practice an opportunity of doing this to the best advantage the Philadelphia Polyclinic has arranged for a special week in ophthalmology, during which at the Polyclinic, at the Wills' Eye Hospital (the latter having the largest hospital and dispensary services devoted entirely to diseases of the eye in America, eighty beds and thirteen thousand new cases annually), and at the other hospitals with which they are connected, the ophthalmic staff conduct the clinics with reference to the standpoint of the advanced student and experienced practitioner. Certain subjects which were of particular interest to the ophthalmic surgeon received special attention. These included the ophthalmometer, the shadow-test, muscular anomalies, fitting spectacle frames, together with the necessary demonstration of methods of clinical work. Other special features of the week will be the series of clinical conferences for the discussion of subjects of general interest, to be participated in by the professors, instructors, and members of the class, and the evening devoted to the study of microscopic specimens illustrating the histology and pathology of the eye, under the guidance of Dr. De Schweinitz.

Many interesting eye cases in the hospital practices of Drs. Edward

Jackson and George E. De Schweinitz could be reported that would be of great interest to the readers of the *American Practitioner and News*, would time and space permit in this most valuable Southern journal, one of the physician's best friends. The advantages to be had in Philadelphia for the study of the eye can not be excelled anywhere, even in Moorefields, London. Students are here at Polyclinic who have spent six to fifteen months at Moorefields, and claim extraordinary advantages for the student of ophthalmology at the Philadelphia Polyclinic. Very many doctors (oculists) have been here from the New York schools, and prefer the teachings, demonstrations, lectures, and clinics to those of New York City. To the students of the South and West the writer would say in all sincerity, come to Philadelphia and take your eye courses.

STANFORD, KY.

VARICOCELE.*

BY T. L. M'DERMOTT, M. D.

In assuming the discussion of varicocele, a seemingly surgical subject, some explanation might be proper upon its introduction by a general practitioner. In these, as well as numerous other distinctly operative cases, however, he is the person first consulted, and upon his judgment and decision largely depend the final measures adopted for relief, so that the question becomes of paramount importance to the patient, and diversely to those intrusted with his management.

The hypochondriasis that accentuates its intensity and in fact first leads the victim to solicit assistance, becomes and remains the leading symptom to invite diagnosis and prompt redress. Such being the case, is it not natural to premise that it opens to the general practitioner a tempting avenue to the administration of treatment for restoring a depleted function, which may require a local surveillance instead of a general cure?

The surgical authorities themselves are at very wide variance upon the advisability of operative procedure, many contending the interference to be useless and even blameful; others, more sanguine, only operating to relieve the incumbent tension and consequent pain. It becomes then a mooted question whether it is entirely proper or mag-

* Read before the Louisville Medico-Chirurgical Society, January 6, 1893. For Discussion see p. 90.

nanimous for the physician to yield up a patient at the expense frequently of personal vanity and always of pecuniary loss.

The literature of the subject, as far as text-books go, is very obscure, and its disquisition entirely inadequate to the magnitude of the issues concerned. Its utility, however, is a matter of unbounded importance possibly to the individual concerned second only to existence itself.

The various morbid conditions of mental deterioration that have found their origin in this, as well as other morbidic sequelæ of a sexual impairment, which saps not only the well-being, but the highest intelligence of pleasurable emotion known to human indulgence, certainly appeals to every scientific endeavor that might encompass its fullest fruition. This phase of the subject is the suggestion of its discussion, prompted in this instance by a letter from a patient who had recently submitted to the operation with the most gratifying results. In this instance he came to consult me, a bridegroom of a week on his wedding tour, asking advice and medicines for the restoration of an incompetency which he attributed to early indiscretions. He was utterly disconsolate over his fruitless efforts to accomplish the marital act, and a prey to remorse intense enough to lead him possibly to some desperate rashness. Upon examination I found a varicocele, and, divining the trouble, advised an operation. It was performed at once, and, as I have said before, with the most rapturous success. I shall read his letter to Dr. W. L. Rodman, Louisville, Ky., written a few months later:

DEAR DOCTOR: Allow me to thank you for your kindness to me, and for the successful manner in which you treated my case. I am entirely well, and feel better than for twenty years past. I have gained seven pounds since I came home, and my wife seems perfectly happy.

Imagine drowned honor dragged up by its matted locks from any slough of despond you could conjure, and any other simile of tragic lore, but what the comparison with this belted knight of Venus springing from the depth of despair thrice armed and eager for the fray? How different the scene since that bridal morn, the church bell changed its funereal dirge to pean strains and frisking birds piped roundelays from bush and dell to greet the gallant groom as he drew near home!

I have another letter to Dr. W. L. Rodman, Louisville, Ky., from another subject, which I shall also read, bearing the same burden in its tenor, and filled with praise:

DEAR DOCTOR: Referring to the operation performed on me for varicocele, will state that I have been much benefited, as I feel that it is impossible to copulate enough at times. Prior to operation I was passionate at times only, but now I believe I can functionate at any time. I feel much better and stronger since the operation, and am sorry I did not have the work done sooner.

It is useless for me to discuss the causes of varicocele, as they are necessarily obscure. I could only suggest that varicosity might be an idiosyncrasy, as we meet it in individuals of all ages, of good or bad habits, and in both the symmetrical and ill-formed. This obtains in the limbs as well as in the scrotum. One peculiarity, however, is evidently due to anatomical configuration, namely, that the seat of varicocele is usually found on the left side. This is due to the spermatic vein emptying into the renal instead of the vena cava on that side.

Of the operations, the open dissection of the veins is certainly preferable, in my experience, to Lee's, in which the vein is ligated. Under antiseptis it is almost absolutely safe, and gives little detention even from business affairs.

In a *resumé* of the cases that have come under my observation I incline strongly to the opinion that in suitable cases, when the testicle is losing its resiliency and becomes softened, the operation should be performed, not only to relieve the distress incident to its dragging weight upon the cord, but also to restore to a lost impulse the franchise of love.

LOUISVILLE.

SYRINGOMYELIA.—Cramer (*Centralbl. f. allgem. Path.*, September 27, 1892), after a review of recent literature, summarizes our knowledge upon this subject as follows: (1) The causation of the disease is obscure. In some cases it appears to have a congenital basis, and a history of trauma is given. (2) The symptoms of the disease may be produced by various lesions; in most cases, however, there is a chronic overgrowth of the neuroglia. (3) The chief seat of the lesion is in the gray matter behind the central canal of the cord. (4) Morvan's disease (paresis, with analgesia, and necrotic conditions, noticeable in the upper limbs) is clinically and pathologico-anatomically a form of syringomyelia. But in it the peripheral nerves may be diseased. (5) Syringomyelia may last two to three years (glioma), or three to four decenniums (simple overgrowth of glia). (6) The cavity originates in destruction of the diseased tissue. (7) The central canal of the spinal cord participates only secondarily in the formation of the cavity.—*British Medical Journal*.

Reports of Societies.

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.*

Stated Meeting, January 6, 1893, Dr. F. C. Simpson, President, in the chair.

Dr. W. O. Roberts: **CASE 1.** About the first of October a man, fifty-five years old, German, had his forearm amputated, at the University Clinic, for removal of an epithelioma of the hand. Last Tuesday he appeared at the clinic again, with a tumor in the axilla on the same side. This morning I removed the growth, cleaning out the axilla thoroughly, leaving nothing except the blood-vessels and nerves. I not only removed the tumor, fascia, and fat from the axilla, but also the skin, which was adherent to the growth. The tumor extended from the floor of the axilla to the apex.

CASE 2. There was also at the clinic a man, twenty-eight years of age, who, thirteen years ago, was struck on the side of his head with a hoe. A few months after the healing of the wound he began to have dizzy spells, and shortly afterward regular epileptic convulsions. The cicatrix left from the wound was exceedingly sensitive, and pressure upon the cicatrix, he claimed, gave him a peculiar sensation in the head. Thinking that possibly this was a case of epilepsy due to imprisonment of a nerve in the cicatrix, I removed it and examined carefully for evidence of injury to the bone, but could not discover any. There have been such cases reported. I saw not a great while ago in one of the New York journals report of a case wherein epilepsy was relieved by removal of the cicatricial tissue from a wound of the scalp. I do not take much stock in the theory, still, as they have been reported, I think that we ought to give these cases the benefit of the doubt, and do the operation.

Dr. W. L. Rodman: I saw this patient when he first came to the clinic in the month of October for amputation of the hand, and was very much surprised to see him to-day in the condition that he was, with all of this enlargement beneath and in the axillary space. It seemed to be a case of epithelioma, and from the general condition of the patient at the time it looked as if it was a very favorable one for

* Stenographically reported by C. C. Mapes.

operation, and as if he possibly would be relieved for several years as a result of the amputation. The question will naturally come up as to whether these glands were enlarged at the time of the amputation, as it has been such a short time since the operation; but I am pretty well satisfied in my own mind that the glands were not enlarged at the time amputation was done. I made a careful examination at the time, and no enlargements could be detected. This was also done by Drs. Vandell and Roberts, who performed the operation. The man was very fleshy, and possibly there may have been enlarged glands which could not be detected. It is a very interesting and unusual case, and teaches us that epithelioma, which we are usually inclined to look upon as the least malignant of all forms of carcinoma (and undoubtedly it is the least malignant, save atrophic scirrhus,) yet sometimes runs as rapid and malignant a course as encephaloid. I have no doubt that this man will be dead in less than six months. He suffered a twelve-month before operation; eighteen months is a rapid course for epithelioma in any situation.

As to the second case, I fully agree with Dr. Roberts in the statements he makes. I have seen a great many operations for epilepsy, and have never yet seen a single case where the patient was permanently benefited thereby. There is sometimes relief for a short period, as a result of trephining, but in all cases that have come under my observation the paroxysms have returned in less than six months after the operation.

Dr. Turner Anderson: From the appearance of the tumor exhibited by Dr. Roberts, it seems to me the operation must have been a very thorough one.

Dr. Roberts: I simply want to say that I never examined the patient from whom this tumor was removed prior to the operation, except last Tuesday, but I know he was thoroughly examined, and, as Dr. Rodman says, no enlarged glands were detected. He was an exceedingly fat man, and of course, if these glands were located high up in the axilla, they would not have been detected. Very frequently in carcinoma of the breast we are unable to detect enlargement of the axillary glands, unless they are of considerable size, until after the axilla has been opened thoroughly and explored, then we wonder why we were not able to detect them before operation. We do have cases of epithelioma followed by encephaloid, and the rule is after removal of a malignant growth, it matters not what form of cancer it may be primarily, whether

it be epithelioma, scirrhus, or otherwise, the recurrent growths are very apt to be encephaloid in character, and are rapid in their development.

I saw a case not long ago of a man, forty years of age, who had what was supposed to be sciatica, and for this he was treated several weeks. Then there was a change in his medical attendant, and the second doctor discovered a lot of growths about the size of an almond on one of the patient's legs; two or three located between the knee and ankle, one just above the knee, one about the center of the thigh on the outside of the leg, and one in the gluteal region, all on the same side. These growths were exceedingly sensitive to the touch, and the man suffered intense pain. At the time I first saw him, about two weeks ago, the growths were very sensitive, and in addition to those I have mentioned there were two or three others in the gluteal region. I told the doctor that I was under the impression that these growths were multiple sarcoma, possibly involving the branches of the nerves, which caused them to be so exceedingly painful. I saw the man again two or three days ago, and several more of these growths had appeared in the gluteal region, and one on the tuberosity of the ischium on that side. We decided to remove one of these growths for the purpose of microscopical examination, and I selected the one on the outer side of the thigh; it seemed quite movable and quite hard. I cut down upon it and found it in the body of the vastus externus muscle, and soft; it came out in pieces; just as soon as I cut through the muscle it welled out like a broken-down neoplasm. From the appearance of the growth I suspected sarcoma; the examination has not yet been made; it was only removed yesterday.

Dr. Rodman: Do you think these tumors have grown any in the last two weeks? And how long has the patient had them?

Dr. Roberts: They do not seem to have increased much in size, but have considerably increased in number. I believe they have all appeared within the last eight weeks. There are certain muscles of the leg which are especially liable to sarcomatous deposits; these, if I remember correctly, are the pectineus muscles, sartorius and glutei muscles. The growth I removed, however, was in the vastus externus. A microscopical examination has not yet been made of the growth removed.

Dr. Rodman: Rare as sarcomas of muscles are, I think that you have such a case. Butlin reports only twenty-one such cases in his work upon malignant disease.

Dr. T. L. McDermott read an essay on Varicocele. [See page 84.]

DISCUSSION.

Dr. Rodman: There has been a wide diversity of opinion among medical men as to the causation, pathology, and treatment of varicocele. The causation of the disease is usually ascribed, as Dr. McDermott says, to the fact that the spermatic veins on the left side disemboque into the left renal vein at a right angle, instead of into the vena cava at an acute angle, as they do upon the right side. This demonstration was first made years ago by my distinguished friend, Prof. Brinton, of Jefferson College. This anatomical point has not been satisfactory to all, and there have been many reasons advanced for the fact that varicocele is so much more common upon the left than the right side. Some claim that it is due to an accumulation of fecal matter in the sigmoid flexure, whereby pressure is made upon the spermatic veins, and the return of venous blood prevented. McGraw, a prominent surgeon of Detroit, Mich., read a very interesting paper upon this subject at the last meeting of the American Medical Association, in which he assigned as a cause of varicocele the action of the cremaster muscle. This I do not believe will hold good, as it does not explain the greater frequency of the disease upon the left side. Others have ascribed the occurrence of varicocele to early excesses, etc. However much we may differ as to the causes of varicocele, there should not be such a contrariety of opinion as to its proper treatment. Many authors do not take a pronounced stand in favor of treating varicocele surgically. To me nothing more imperatively calls for operation than an aggravated case of varicocele. Moulton, one of the most recent authors, has very pessimistic views upon the subject, and only advises operation in the most extreme cases, when there is disintegration of the testicle. He also magnifies the danger from operation. His personal experience must be limited. I believe there are very few varicoceles of any size which last for five or six years, where there is not a considerable injury done the testicle, and when this can be prevented by so simple and safe an operation it seems to me that it should be done more frequently than it is. I can understand very well how the older authors argued against operations for varicocele, because none of the operations practiced prior to the last five or ten years were an approach to the ideal. Subcutaneous surgery is surgery in the dark. I did very few operations for varicocele until within the last five years; since that time I have done quite a number

of them. In the last year I have performed, I think, on an average about one per month. I feel that it is at times one of the most humane and considerate operations that can be done. Wherever I find there is a well-marked swelling or tumor caused by enlarged veins, where I find pain or dragging of the testicle, where there are lumbar pains, etc., whether accompanied by any grave cerebral symptoms or not, I advise early operation. If a man has a simple varicocele, and has never worn a suspensory bandage, especially if he be a young subject, I advise him to try a bandage for six months or a year, and then if there is no improvement I urge operation. Only a few days ago I declined to operate upon a young married man, telling him to procure a suspensory bandage and wear it for a year, then if he received no benefit to come to me again and I would operate.

I want to give the history of the first case referred to by Dr. McDermott: He was a man about thirty-seven years of age, and, as the doctor has stated, he came to his office about a week after he was married. He was referred to me, and when he came to my office I noticed his actions were very peculiar; he came into the room and was very particular to close the door carefully, and afterward to look around to be sure there was no one present. He then slipped up to me, and in an undertone remarked, "Doctor, I am a victim." I asked him, A victim of what? to which he replied, "Early excesses." He then said that he had been to see Dr. McDermott, who had made an examination and told him he had a varicocele, and advised his consulting me. I made a careful examination and saw that his case was a very extreme one. I have seen very few cases where there were such marked mental symptoms, and where there was such prompt and thorough relief by simple operation. He also told me that he had attempted intercourse twice since marriage and had utterly failed, that he was unable to get an erection, but had one imperfect emission. I sent him to the Infirmary, and operated the next morning. I told him when he left not to attempt intercourse until the third week after the operation. I did not hear of him until about a month afterward, when he came into my office one day, and I never saw greater change in a man's appearance in my life; the first thing he said was, "Doctor, I am all right." I asked him more particularly what he meant by being all right, and he said that he had no trouble, and could have intercourse as well as he ever could in his life. I inquired as to the frequency with which he could perform the marital act, and he replied two or three times per week. He had been married about two

months. We afterward received a letter from him, which was read by Dr. McDermott, confirming the assurances he gave in person that he was entirely relieved. The results in this case are certainly gratifying, and I feel safe in saying that no treatment by electricity or other means could have brought about the same relief as by operative procedure.

In all the cases I have operated upon for Dr. McDermott in the last six or seven years, four of which have occurred in the last year, I can conscientiously say, and he will bear me out in the statement, that there has not been a single one of them that has not been entirely relieved. They have not only presented the appearance to me of being relieved, but each one has assured me that he felt perfectly well in every respect. I do not know that I have ever done a varicocele operation where the results were not all that could have been expected. In certainly twenty or thirty operations of this character that I have performed in the last two years I only call to mind one case where the patient claimed that he was not relieved, and yet all the facts in the case tend to prove that he was entirely cured. Three or four years ago a young man was brought to me by a physician of Lawrenceburg with a varicocele on the left side. I operated upon him at the St. Joseph's Infirmary, and he remained there about two weeks. I thought he was entirely relieved of the trouble, in fact he said so himself. He went home, and I heard nothing more from him until I sent him my bill, which he declined to pay, stating that he had not been cured, and for that reason refused to pay the bill. However, I learned through his physician, who examined him, that he was entirely cured, and am certain that he was. He married, which is a confirmation of it, in less than six months after the operation, and has two children now. I believe that the modern operation of excision and removal of about an inch of the veins and suturing the stumps accurately, so as to lift the testicle up, is the ideal operation, and I can not agree that there is any danger in it, as some authorities would have it appear, as I have never in my own experience seen a single untoward symptom. I have only seen one case of orchitis following varicocele operation, and that was in one of my earlier operations. As I have said, no unfavorable symptom has occurred since I have practiced the open method as described above. I rarely see suppuration. I prefer iron-dyed silk for suturing the veins.

Dr. T. S. Bullock: I have enjoyed Dr. McDermott's paper very much, and can testify to the extreme nature and frequency of this trouble. I would like to say a word or two in regard to the causation.

I have always thought varicocele in part was due to the frequent excitement of sexual sentiment without gratification. I believe that there are very few young men who remain unmarried for any great length of time, who have not unusual facilities for sexual pleasures, that escape without varicocele.

Dr. Roberts: I have very little to add to what has already been said with reference to this subject. Varicocele is an exceedingly common affection, and it occurs in the young as well as the old. There is no doubt that in young subjects the disease sometimes passes away under appropriate treatment; after adult age, however, I do not believe it ever goes away. As to the cause of the disease, it has been attributed, as Dr. Rodman says, to quite a number of things. It rarely ever occurs on the right side. I notice that in Agnew's examination of thirty thousand troops he never discovered a well-marked case on the right side. Cooper, Marshall, and others also report not having found a single well-marked case on the right side. It does, however, sometimes occur, and occasionally in the same subject on both sides. I have, during the past three months, had a case of this kind, in which I operated first on the left side, and two months after operated on the right side. As to the indications for operation, I think that we are justified in advising it when we find cases of varicocele of long-standing, where there is evidence of wasting of the testicle, where the patient suffers from dragging pains in the loins, and where we want to operate for the purpose of relieving the mental condition which it gives rise to in a great many instances. There are many cases, however, of large varicocele in men who understand it, you might say, who are not frightened by it, where it does not seem to affect their virile power in the least. Still in these cases, where there is evidence of wasting of the testicle, I think operation should be advised.

As to the different methods of performing the operation, between the subcutaneous and the open method, I strongly favor the open method. I have done every operation that has ever been advised for varicocele, excepting one, viz., the removal of a large section of the scrotum for the purpose of making a natural suspensory. In former years I did, as Dr. Rodman says he has done, the subcutaneous operation; I have long since, however, given it up. In these cases I find that the patient very frequently suffers from a neuralgic condition of the cord which continues for months and months. I have seen follow these operations abscesses, which, of course, must have been due to want of proper aseptic precau-

tions. The open method, I think, is decidedly the safer procedure. It is an exceedingly simple operation, and is one which can be done under anesthesia, the other can not. Where subcutaneous ligatures are applied, you want to have the veins distended so that you can discover them. In doing this operation I make a free incision over the cord and expose the veins. I always remove a large section of the veins, an inch or more, and then bring the stumps together. The method mentioned by Dr. Rodman is an excellent one: after ligation of the veins above and below, the central portion is removed, then the ends are brought together and stitched, which brings the testicle well up. I have performed the operation in this way a number of times with the most happy results. Recently I have been following the method advised in the American Text-book of Surgery, which is as follows: The veins are exposed, but not separated from the fascia surrounding them and holding them together; the vas, with its venous plexus, is recognized and avoided. An aneurism needle threaded with catgut is then passed under the vein at the upper end of the incision and again at the lower end; the ligatures are tied, and in each instance left with one long end; the intermediate portion of the veins is then cut out with scissors and the stumps are brought into apposition and held by tying the ligature ends together. This method, like that of stitching the stumps together, raises the testes to a higher level, and results in shortening the scrotum on that side.

Since I adopted the open method of treatment in varicocele I have met with only one case in which I had any trouble. That case was in a dissipated man, and the varicose veins and scrotum were very large and the testicle very small. Following the operation there was suppuration, and, while it was not excessive, it continued for some little time, but there was no sloughing noticed, and the man finally got well. I saw nothing more of him for a year. He came to my office the other day and asked me to examine him; I did so, and found that the testicle on that side was gone entirely.

Dr. Turner Anderson: I would like to inquire how the circulation is kept up after removal of a portion of these veins; I should think there would be great danger of atrophy of the testicle.

Dr. Rodman: I fully agree with what Dr. Roberts has said in regard to double varicocele, and was a little surprised to hear him quote Agnew as having stated that there was not a single case occurring on the right side. I have seen two cases of double varicocele in the last six months.

The man who wrote the first letter read by Dr. McDermott had a very small varicocele on the right side, but it was not operated upon owing to its small size, and it was evidently the one on the left side that was giving him the most trouble. I operated upon a man at the City Hospital, about three months ago, who also had double varicocele, and I do not think it is as uncommon as has been reported. Another point that might be mentioned in this connection is that men with varicocele are not accepted either in the army or navy. One reason why the modern operation is so much better than the old subcutaneous method is, that in the subcutaneous operation you can never tell just exactly what structures you are embracing in the ligature cut, but with the open method you can see just what you are doing.

Dr. Anderson's question is very easily answered. It is only the superficial veins that are enlarged in varicocele, and there are a number of smaller veins situated deeper that are sufficient to carry on the circulation. That these deeper veins are sufficient to carry on the circulation is shown by the fact that they may so enlarge as to necessitate a second operation. In the ordinary operation only the superficial veins or "pampiniform plexus" are removed. Relapses are rare.

Dr. T. L. McDermott: In all these cases that I have had with Dr. Rodman I have noticed that the testicle was always smaller on the side on which the varicocele occurred, the testicle seeming to be very much shrunken, in some cases exceedingly so. I think the operation clearly justifiable when such happy results can be accomplished as those stated in the paper read this evening. There is very little information in the text-books concerning operations for this trouble, and I believe if more were known of the benefits to be derived from so simple an operation, if people would look into it more, the operation would meet with more general favor.

TUBERCULOSIS AND LACTATION.—At the Pediatric Congress recently held at Naples, N. Fede (*Rif. Med.*, October 25th) said he had made experiments as to the transmissibility of tuberculosis by mother's milk by inoculating, with antiseptic precautions, guinea-pigs (under the skin and into the peritoneal cavity) and rabbits with the milk of tuberculous women. In no single instance did any of the animals show signs of tuberculosis. He added that in no case did the milk contain bacilli, however far advanced the pulmonary disease was. De Bonis, from experiments made by himself, had come to the same conclusion as De Fede.—*British Medical Journal*.

THE LOUISVILLE CLINICAL SOCIETY.*

Stated Meeting, December 13, 1892, Dr. I. N. Bloom, President, in the chair.

Dr. A. M. Vance: I simply present this patient to show the result of double excision of the knee for infantile paralysis. The boy is about nine years old, very small for his age; his body is fairly well developed, but the legs are very small. I first operated upon the left leg, then after a lapse of about five months excised the right knee. You will notice I have put one leg in slight flexion, the other in hyper-extension, by this means hoping that he may be better able to balance himself in walking. I used no suture whatever in uniting the bones, the plaster dressing serving to keep them in apposition; I first removed the patella, then about half an inch of the tibia and femur. There has not been the slightest sign of inflammatory reaction or suppuration from either operation, proving the power of asepsis in these cases. I have done this operation five times on the knee and twice on the ankle; the last patient operated upon died, about ten days after the operation, with some trouble of the heart.

Dr. I. N. Bloom: In case the operation had not been performed and the paralytic condition allowed to exist, there would have been complete atrophy of the muscles. I would like to ask Dr. Vance if he expects muscular development now?

Dr. Vance: All the calf muscles that move the foot and are not paralyzed will develop by use.

Dr. W. O. Roberts: There seems to be a good bony union. Have you ever noticed in any of these cases, after you have apparently secured good bony union, it afterward limbers up?

Dr. Vance: No, I have not; the bony union has always been permanent.

Dr. Roberts: One important point in an operation of this character is to get, if possible, bony union, and in order to do that it seems to me you are bound to take off the cartilage of both bones. If you do not, you get what is called "flail" joint. Another point you have to be exceedingly careful about in removing a piece of bone, is not to take off too much; if you do the bone ceases to grow. This is a very important point in cases of resection in children.

Dr. T. P. Satterwhite: Dr. Dugan, I believe, performed a laparotomy

* Stenographically reported by C. C. Mapes, Louisville.

upon this patient about a year ago; the stitches inserted at the time seem apparently to have cut through, and there is a cheloid condition running across the abdomen from each stitch as large as a small lead pencil. She is a Polish girl, about eighteen years of age. The operation referred to, as I understand, was an exploratory one, owing to some ovarian trouble which was supposed to exist. However, every thing was found to be in an apparently healthy condition, consequently nothing was removed.

The point that I wish to call particular attention to is, that she now claims to have an evacuation of the bowels only once in three or four weeks. She speaks English so imperfectly that it has been exceedingly difficult for me to obtain a full history of the case. She tells me that she suffers intensely, probably from the accumulation of fecal matter, and that a colotomy has been proposed for her relief. That is a point upon which I desire to obtain the judgment of the Society as to the propriety of further operation. She came to me for advice as to whether she should submit to an operation. She says one half of her body (left side) is perfectly devoid of sensation; a needle can be thrust into the body on that side without pain; there is perfect sensation of the opposite side. There is no loss of motion of any portion of the body, but simply loss of sensation on one side, which has existed for about eleven months. She has been troubled with constipation for about a year.

CASE 2. Many of you have seen this patient, as he has been in the City Hospital a greater part of the time for the last year or so. I simply had him come here to show the development of the superficial veins on the upper part of the trunk. These veins commenced enlarging about a year ago, and you will observe now they are nearly as large as your finger. A peculiar feature is that the blood flows downward in these veins, as can easily be proven by compressing them at either extremity.

DISCUSSION.

Dr. W. H. Wathen: If I understand correctly, one of the especial reasons for reporting the first case was to get the sense of the Society as to whether colotomy is indicated. This woman consulted me some six weeks ago upon two or three occasions, but I found that she was not a patient that would interest me especially, and declined to see her again. I can see no indication for a surgical operation of any kind upon her bowels, or upon her uterus or its adnexa. Colotomy could do no

possible good, but might do a great deal of harm, because it would bring about a very disagreeable condition by keeping the patient constantly soiled with fecal matter. I can not understand why colotomy should have been suggested, because there is no apparent obstruction in any part of the canal, and we have no positive assurance that this woman has constipation at all. In fact I am inclined to the opinion that she is having evacuations with comparative regularity. I do not mean to claim that she is purposely deceiving the profession, for she may be absolutely honest in what she says; she is probably insane upon the subject. Were she having as few evacuations as she claims, there would be conditions that do not exist.

Dr. Satterwhite: In regard to what Dr. Wathen has said, that there would be some constitutional disturbance if a patient did not have an evacuation oftener than stated by this patient, let me state that I had an Irish servant girl with me about thirteen years, and she never had an action of the bowels for three and four weeks at a time, and during this period she was in excellent health. Never was sick in the thirteen years, and she reported to me at the time that there was a woman next door in exactly the same condition.

Dr. Bloom: You are all doubtless familiar with the report in physiology of a man who went eight months and sixteen days without having an action of the bowels, and was in perfect health all the time, and when he did have an action there was a large amount of fecal matter, over fifty pounds, I think. Cases of this kind are not so very uncommon. An examination of the abdomen is bound to disclose an abnormal condition, while the sensations of the patient may be those perfectly consistent with good health.

Dr. Vance: I have seen a great many cases of varicose veins on the trunk, and do not think the condition very uncommon. I expect I have seen at least twenty-five cases, some of which were more marked than the one shown by Dr. Satterwhite.

Dr. Roberts: About two weeks ago I was called to a neighboring town to see a gentleman who had fallen a distance of some twenty feet, sustaining a complicated fracture of the bones of the forearm. The arm was put up in plaster dressing and kept there several days. At the end of a week his physician discovered evidences of gangrene. When I saw the patient, seven days after the receipt of the injury, gangrene was quite marked, and extended to within two inches of the elbow-joint. The parts above were very much swollen, and there was consid-

erable contusion and ecchymosis of the arm on the inside as high as the axillary space. The patient's temperature was 104° F.; pulse, 130. The temperature the day before, the doctor told me, was only 101° F.; on the morning of the day I saw him it was 102° F. I saw him about four o'clock in the afternoon, and advised immediate amputation, and did the operation at the junction of the middle third of the humerus. I had a letter from the doctor a week after the operation was performed, saying that at nine o'clock at night of the day of the operation the patient's temperature had fallen to 100° F., and since that time it had not gone above 99° , and that there was union nearly throughout the whole line of the incision.

T. C. EVANS, *Secretary.*

LOUISVILLE.

Reviews and Bibliography.

Treatise on Hygiene. Edited by Stevenson and Murphy. Philadelphia: Blakiston, Son & Co.

At this time, when the subsiding cholera panic has so directed general attention toward practical questions of sanitation and public hygiene, this work is especially noteworthy. The editors are known by their past work to be thoroughly practical and conservative men, and hence the scope of this treatise is not confined by an undue desire for uniformity of statement from the different essayists. The editors' efforts have been toward a fair selection of properly equipped men qualified to deal with the ordinary subjects dealt with in like treatises. That they have succeeded, the names of Corfield, of Coleman, of Nolter, and of others possibly not so well known to American readers, are the best evidence. The authors have been clear without verbosity, succinct without obscurity. For studied moderation of statement, for lucidity of reasoning, and for absence of meddlesome argument on mooted points, their efforts are commendable. It has perhaps been too much the habit of writers on questions of State Medicine to italicize every point past the limit of adherence by the general medical world.

Especially has this been true on our side of the Atlantic, and this has been because an American writer feels a certain lack of confidence in his public. Certain it is that there has not been developed among our people that desire for intelligent co-operation with public health officials which can be so clearly seen in Great Britain and Ireland and on the Continent, and so their sense of power given by public co-operation has given the English writers moderation of tone and ability to disagree on public physiology and pathology without undignified bickering. This is all evinced in

the present work, where physicians, surgeons, architects, and chemist analysts have traversed their often varying views without reproach, and with benefit to the reader and to the great cause of preventive medicine. So much has been done in the domain of the natural history of disease in the past few years, and the influences of the soil, the air, and the water supply have been so much better understood that the old idea of filth as a general cause of disease needs to be replaced by more exact information as to what particular diseases are so produced, and in what manner and degree.

This information is well supplied by this general treatise, and so perhaps the articles upon air, water, and soil, as causative forces in disease, in this volume, will be most serviceable to the medical public. That all will agree with Dr. Coleman in his bold assertions of the far-reaching influence of the soil as a disease conveyer, can not be expected, but the most obdurate objector would admit that his case has been fairly stated and objections clearly met. The influences of the air, of water (its supply and subsequent drainage) are not less efficiently dealt with by their proper essayists, and the article on the disposal of waste products and refuse is far and away the best presentation of modern views and performances in that direction ever presented to the public. No sanitarian or health officer should fail to be acquainted with the contents of this thesis.

Not less interesting are the ideas given in the article on physical education. It might well serve as a text-book in our high schools, instead of the fragmentary and useless works on physiology on which time and study are so often wasted.

In fine, the general idea of this work is so good, and so well carried out in its inception, that one can but strive not to overpraise. Owing to rapid advance in exact information, all such books are necessarily tentative in statement and ephemeral in value, but until time has taught us much knowledge that we now lack this work must continue to be a standard one.

C. M.

A Treatise on Diseases of the Nose and Throat. In two volumes. By FRANK HUNTINGTON BOSWORTH, A. M., M. D., Professor of Diseases of the Throat in the Bellevue Hospital Medical College, etc. Volume II. Diseases of Throat, with three colored plates and one hundred and twenty-five wood cuts. Wm. Wood & Co. 1892.

Three years ago we gave an extensive notice of the first volume of this treatise, and commended it highly. The volume now under review finishes the work, and taken together they form a most valuable addition to the literature of rhinology and laryngology. While this book does not contain as much new material as did volume one, it is probably more valuable. The enthusiasm of its author is still apparent. It is divided into three sections. Section 1 is given up to the study of diseases of the fauces. Very distinct lines are drawn between the different diseases. Probably the most interesting is that part devoted to diseases of the tonsils. Here we find a well-defined classification of the different diseases occurring in the tonsils.

First he takes up quinsy, and shows very plainly that it is not an inflammation of the parenchyma of the tonsils as many teach and many more believe, but an inflammation starting in the peritonsillar structures. A thorough understanding of this is required of the surgeon who attempts to incise such abscesses. We have often seen cases that give a history of having been cut a number of times without relief; and in each of them an attempt has been made to reach pus through the tonsils, under the belief that the pus was located in the tonsillar tissue, when a small incision through the structures of the soft palate in front of the tonsil would have probably quickly evacuated the offending material. Further, many submit to the removal of remnants of the tonsil under the belief that they are removing the offending part, and yet fail to always get immunity. Dr. Bosworth's teachings show plainly the cause for this is that peritonsillar abscess or quinsy has as its predisposing cause some diathesis, probably rheumatism, and not the mere presence of enlarged or diseased tonsillar tissue.

The chapter on Acute Follicular Tonsillitis can be read with advantage. Yet I think a great mistake has been made in calling it croupous tonsillitis, since it gives authority to many who are prone to call such cases diphtheria. While diphtheria is most often found in the early stage on the tonsils, it is a very different disease from follicular tonsillitis. Yet such expressions as "croupous tonsillitis" would lead one to think there was some intimate association between the two diseases. And I am sure the two diseases are frequently considered as synonymous. A few years since I heard a member in the Section of Laryngology of the American Medical Association say that he had treated eighty consecutive cases of diphtheria without a death, all by local applications to tonsils, and without laryngeal involvement in a single instance. Surely the majority of these cases were "follicular tonsillitis."

Section 2 treats of diseases of the larynx, and is most interesting, yet we have not the space to dilate upon the many good points to be found therein. Section 3, Exterior Surgery of the Throat, closes the volume. It is a work of which the author should feel proud. It shows extensive reading and a complete knowledge of the literature of the subject. No throat specialist can be without it, and while it appears voluminous for the student, he will find it most interesting reading, and it will fully repay him for the time expended.

J. M. R.

A Manual of Bacteriology. By GEORGE M. STERNBERG, M. D., Deputy Surgeon-General U. S. Army. William Wood & Co. 1892.

Upon receipt of the notice that the publishers had sent us a copy of a new work on Bacteriology by George M. Sternberg, M. D., we were prepared to receive something above the average. Our pleasant anticipations were more than realized when on the following day the express man placed in our hands the magnificent volume that bears the above title. The work covers eight hundred and eighty-six pages, and is complete in every detail,

being fully illustrated by heliotype and chromo-lithographic plates and two hundred and sixty-eight illustrations.

The rapid development of the science of bacteriology in the last decade made possible by the improved technique of Koch, and the hundreds of workers following and improving upon his methods, renders it extremely difficult to keep pace with this progress, even when one has the advantages of the literature and a laboratory at his command. Our methods have been more exact of late, and former errors have been gradually wiped out, and the studies of one trained observer confirmed by scores of others, until now the results can be accepted as well established. This is particularly true of most of the infectious diseases of man and the lower animals. There remain, however, a few diseases about which we are still in doubt, and some in which we have been totally unable to determine the cause. The future holds brilliant promise that further improvement in technique will enable us to determine the exact nature of all of the infectious diseases, and that the day is not far distant when each specific disease will have its specific remedy.

One who reads the brilliant collation of facts contained in this work can not fail to be impressed with the importance that this branch of our science has already assumed. It is a work representing the latest knowledge in relation to the causes of infectious diseases, taken from the highest authorities, full discussions on the subjects of susceptibility, immunity, and modes of infection and means of prevention. It is characterized by great originality of thought, concise description, and full directions in the art of cultivating, staining, and studying all of the well-known pathogenic and non-pathogenic bacteria. It is a work which every student of medicine should, if necessary, be willing to deny himself a few pleasures to obtain, and one which every progressive practitioner fails to do justice to himself if it is not found in his library.

H. M. G.

The Pulse. By WILLIAM EWART, M. D. (Cantab.), F. R. C. P., Physician to St. George's Hospital, Clinical Teacher and Lecturer of Practical Medicine in the Medical School, etc. William Wood & Company. 1892.

A practical work for beginners on "how to feel the pulse and what to feel in it." A book of one hundred and seven pages, exhaustively indexed and paragraphed for ready reference. Chapter II, on "Tension," with its subdivisions, is treated more exhaustively than others. In the note on "various sites for feeling the pulse" the author rightly lays stress upon the use of the temporal artery for feeling the pulse of a child or of a sleeping patient.

The table on the "influence of age" on pulse-rate is from Stirling's translation of Landois' Physiology. The other tables are well selected.

The author encourages the use of special names of pulses in his paragraph on "classical varieties of uneven and irregular pulse," as well as in his glossary of terms, from which many other obsolete terms could be left out.

The use of the names of men who first described pathological conditions as a name for that condition is also encouraged by terming the "pulse of aortic regurgitation" Corrigan's pulse. The work will do well for students of medicine "by directing their attention to the oldest and not least important of our methods of clinical study."

H. E. T.

Manual of Practical Medical and Physiological Chemistry. By CHAS. E. PELLEW, A. M., Demonstrator of Physics and Chemistry in the College of Physicians and Surgeons. New York: Appleton & Co., Publishers.

This work is divided into nine parts, each part being subdivided into lessons. The first three parts deal with the chemical and physiological characters of the carbo-hydrates, fats, and proteids. The importance of a knowledge of the chemical properties of these substances to the practical physician can not be overestimated, and the author is to be congratulated on the simplicity with which he has presented his subject. The parts devoted to water analysis and the urine seem to me to be rather incomplete, in the latter dealing more with the chemical rather than with the clinical aspect of the subject. The two are inseparable, and should be taught side by side. The work also deals with food and its products, and with the various fluids and tissues of the body. The tests for breast milk and gastric juice are the latest and best. Altogether the work is first class as a manual for the physiological laboratory and as a work of reference to the busy practitioner.

H. M. G.

NUTMEG POISONING.—G. E. Reading (Therapeutic Gazette, September, 1892,) records the following case of poisoning by nutmeg. The patient was a lady, three months pregnant, who, in order to procure abortion, swallowed three powdered nutmegs, and was only prevented by fear of vomiting from taking a larger amount, and thus losing the whole. She was well till three hours after, when she vomited several times, passed into the following condition: Low, muttering delirium, with occasional silly laughter, and hallucinations of a ridiculous character. She could be aroused from this by shaking, but would relapse almost immediately. There was also a strong sense of impending death. The pulse was strong and rapid. The treatment adopted was to give a twenty-grain dose of chloral hydrate, which lessened the delirium and allowed the patient to obtain sleep. The delirium continued to recur, however, at intervals for the next twenty-four hours, during which grain doses of calomel were given every hour; the next day the patient was quite rational. It may be added that the object for which the nutmeg was taken was not accomplished, the whole energy of the agent appearing to have been expended on the nervous system and gastrointestinal tract. The general symptoms of poisoning strongly recall those which appear in some cases of poisoning by cannabis indica.—*Brit. Med. Jour.*

Foreign Correspondence.

LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

Death of Mr. Baker; The Plumbers Company; Christmas Festivities; Sulphur in Anemia; A Distinguished Visitor; New Method of Artificial Respiration; A Rhinolith; The Marriage Rate; Baron de Hirsch; The Expense of the Scarlet Fever Epidemic; Professor Victor Horsley.

Mr. Alfred Baker, the well-known surgeon, has just died at his residence near Birmingham. Mr. Baker took an active part in the work of the British Medical Association, and was unanimously elected president for 1872-73, when the members met in Birmingham. Mr. Baker was uncle of the present Archbishop of Canterbury.

At a court of the Plumbers Company, over which the Lord Mayor presided, a communication from Professor Smith on behalf of the Governors of King's College was received, offering the use of workshops lighted by electricity, and the physical and chemical laboratories for advanced technical instruction for plumbers in connection with the company's educational scheme. On the motion of Sir Philip Magnus a committee was appointed to prepare a scheme by which selected students from the Metropolitan Plumbing School may have the opportunity of attending a course of advanced instruction at the college.

By the observance of an annual custom the patients of University College Hospital have been made to forget their sufferings in the delight of a Christmas entertainment. About 300 invitations were issued to the supporters of the institution, who on these pleasant occasions are wont to inspect the hospital, which is made gay with flowers and yule-tide decorations. The entrance hall was bright with festoons of colored lamps and adorned with oriental draping, while the wards were made cheerful with Christmas flowers. For the children a special treat was afforded in the shape of a giant tree filled with toys and illuminated by electric glow-lamps. In the out-patients' room, whither some fifty of the inmates, old and young, were carried, a capital concert arranged by the medical officers took place, and subsequently a quartette party went round the wards and cheered the sufferers with tuneful carols.

Attention has been called to the great value of sulphur in certain cases of anemia. The following conclusions are stated to be the result of careful observation: (1) In cases of pure chlorosis in which iron proves inefficient, the general condition is decidedly improved by sulphur. (2) After the

administration of sulphur has gone on for some time, treatment with iron can be commenced and continued with success. (3) In cases of chlorosis complicated with catarrhal and inflammatory conditions of the digestive tract sulphur is not tolerated. The best mode of giving the remedy is found to be in the form of flowers of sulphur mixed with sugar of milk (one of sulphur to two of lactose).

A distinguished visitor was present at the last meeting of the Royal Medical and Chirurgical Society. Dr. Mirza Ali, chief physician to the Shah of Persia, and professor of medicine in the University of Teheran, joined in the discussion which took place after the reading of a paper upon a subject connected with gout, and remarked that gout was only met with in Persia among the rich, the only class who ate animal food.

A new method of saving life from asphyxia is reported in two cases when it was successfully tried in two people apparently drowned, in which it seemed that all hope of resuscitation was lost. The method is to draw out the tongue and jerk it rhythmically. This produces an artificial hic-cough, which excites the diaphragm to contract and the heart to resume its function, restoring respiration and circulation. At the same time the epigastrium should be fomented with scalding water even to blistering.

Dr. Moritz, the consulting chemist of the County Brewers Society, read a paper recently from which it would appear that the amount of salt directed to be used by European armies varies considerably, inasmuch as the limit in the English army is 110 grains in the foods daily, while in Germany it is 382, in Austria 264, and in France 220. The English limit is considered too low.

At the Clinical Society of London, Dr. de Havilland Hall, in showing a rhinolith, remarked on the relative rarity of such specimens, as no example had previously been exhibited at the Clinical Society, and only four at the Pathological Society. There were, he found, only six specimens in the medical museums of London. Dr. Hall's specimen had occurred in a young female patient, aged sixteen, who had suffered from a fetid discharge from the left nostril since the age of two and a half years. The left nostril was almost stopped up by a mass of stony hardness, the greater part being in the inferior meatus, but projection extended into the middle meatus. After numerous sittings the stone was removed piecemeal by means of the forceps. The largest fragment was noosed by a wire loop, and forcibly pulled out. The application of a 20-per-cent solution of cocaine was found to greatly facilitate operations. The fragments, after washing and drying, were found to weigh 92 grains, and to consist of organic matter 26.4 and calcium phosphate 73.6 per cent. There was no nucleus. Dr. Hall drew attention to a monograph by Dr. Max Seeligmann, who had collected records of 110 cases, besides a few others of which he was unable to obtain full details.

Already 1891 is a long way back, but the Registrar-General's report for that year to the Local Government Board has just been issued. The most

interesting part in it relates to marriages. During the twelve months mentioned the number of marriages was 226,526, or at the rate of 15.6 per 1,000 of population. In 1886 the rate was only 14.2, but it has steadily risen ever since. The average marrying age for men is twenty-eight years, and for women twenty-six. Statistics show that early marriages are becoming rarer, the general tendency now being to defer the event until some experience of life has been gained. For a long time prior to 1874 it appears marriages in which one or both of the parties were under twenty-one abounded, the proportion being 84 in the thousand for men and 227 for women. Since the year mentioned they have steadily declined until the rate now stands at 59 for men and 190 for women.

The hospitals are beginning to reap the benefit of the £28,000 which Baron de Hirsch won last year on the turf. He has already given £1,200 to the Children's Hospital, Great Ormond Street, £700 to the Royal Free, £300 to the Paddington Green Hospital, £700 to the Great Northern Central, and £700 each to the Northeastern Hospital, Royal Hospital for Women and Children, and to the Metropolitan Hospital. It is stated that it is the Baron's intention to dispose of the whole of his winnings to various charities.

Some idea of the cost caused to the rate payers of the metropolis by the epidemic of scarlet fever which has been prevalent for a good many months now may be gathered from a letter which has been sent to the local authorities by the Metropolitan Asylum's Board. It states that in consequence of the fever the expenditure of the board for the past six months had exceeded the estimate by £103,478. One parish, Hampstead, is called upon to make good as its share £2,162.

Professor Victor Horsley has begun a course of ten lectures at the Royal Institution on "The Functions of the Cerebellum and Elementary Principles of Psycho-Physiology."

The Prince of Wales has expressed his intention to be present at the Royal College of Surgeons on February 14th, on the occasion of the delivery of the Hunterian Oration by the President of the College, Mr. Thomas Bryant.

LONDON, January, 1893.

TREATMENT OF LUPUS.—Robinson, of New York, who had found pyoktanin to be without effect in cancer and lupus (*Journal of Cut. and Gen. Urin. Diseases*, September, 1892, p. 365), has conceived the idea that such patients should be fed with the flesh and secretions of animals not liable to tuberculosis, as fish, lobsters, etc., and the flesh and milk of goats, upon the theory that the human protoplasm takes on the molecular constitution and properties, to a large extent, of the protoplasm of the organism upon which it feeds. By this course he believes the soil may be made unfavorable for the existence in it of the bacillus of tuberculosis.—*British Medical Journal*.

Translations.

CHOLERA: THE DIFFERENCES IN THE BEHAVIOR OF THE CHOLERA IN THE DIFFERENT EPIDEMICS (*Deutsche Medizinische Zeitung*, 10-10, 1892.—By Dr. J. Michael, Hamburg.) The epidemics considered are those of 1830-'31, 1848, 1873, and the recent one. The older practitioners who had had personal experience with cholera in the epidemics of 1848-'73 had made the observation that the onset of the cholera was usually preceded by premonitory symptoms, a diarrhea which lasted several hours or even several days, and ushered in the real attack of cholera. Further, that persons who had withstood the algid stage without succumbing had a very fair chance of recovery, the occurrence of the so-called cholera-typhoid being comparatively rare. The disease usually lasted from twelve to thirty-six hours. Wunderlich and Griesinger in their well-known descriptions have given about this description of the disease, a duration of twenty-four to thirty-six hours and the occurrence of premonitory diarrhea, and the relatively rare occurrence of the cholera typhoid. For this reason the younger physicians in Hamburg, who only knew the disease from descriptions, were surprised to find very different occurrences from those mapped out in the text-books. In the recent epidemic prodromal diarrheas occurred very seldom. The duration, whether ending in death or recovery, was only a few hours, and of those who withstood the algid stage a very great number succumbed to the cholera typhoid.

The subcutaneous injection of saline solutions is the only method so far tried, and every thing has been tried which has reduced the mortality in the algid stage from about 80 per cent (Griesinger) to 58 per cent (698 collected cases from various observers, with 298 recoveries). From the treatment with toxine very little is to be hoped, because one attack of cholera itself does not render the patient immune for even a short time. In Hamburg, in the course of a few weeks, two and more attacks of cholera in the same individual have been observed. The following table, prepared by Dr. Krempin in Woronesch, will give interesting comparisons between the two epidemics of 1830 and 1847:

1830-'31.—1. The disease ran usually a very rapid course. Death generally occurred in six to twelve to eighteen hours after the first onset.

2. The onset occurred mostly suddenly, without any forewarnings.

3. As a rule, no other disease succeeded. Either death or recovery without more ado occurred.

4. The symptoms peculiar to the disease lasted to death or the occurrence of reaction.

5. Children were scarcely ever attacked. There was scarcely an example of a child at the breast being attacked.

6. The matter vomited and purged was generally very plentiful and uncolored.

7. Bleeding did not harm as a rule, when at the same time it did not seem to help in any way.

8. According to results of *post-mortem* findings death could usually be attributed to an affection of the spinal cord and the surface of the stomach. Collection of blood in the ventricles of the heart occurred, but only then when the patient died secondarily of typhoid or of intermittens apoplectica.

1847.—1. Course less rapid. Death generally in thirty-six to forty-eight hours.

2. Only very seldom was an attack without all premonitory symptoms. Generally there was for one or several days digestive disturbance, coated tongue, loss of appetite, colic, diarrhea, and only very seldom constipation.

3. The disease terminated frequently in (*a*) cholera typhoid, (*b*) diarrhea that lasted sometimes ten or more days, (*c*) mental derangements which without fever frequently ended fatally toward the end of the second week.

4. After the cessation of the characteristic symptoms and the occurrence of the stage of reaction with warmth, sweating and reinstallation of the pulse, not infrequently a new attack occurred, sometimes in six hours, sometimes sooner.

5. No age was exempt, and especially were children more frequently attacked than adults. Deaths of children at the breast were not rarities.

6. The dejections in most cases were not frequent nor copious. During the duration of the cholera symptoms there were often only eight to ten vomitings and as many stools that not seldom were colored. The stools toward the end of the epidemic in Woronesch were not infrequently like the stools in dysentery, and were like flesh-water.

7. Venesection was generally hurtful, but application of eight to ten leeches in regio-epigastrica was very serviceable when the respiration was shallow and this region very tender.

8. In nearly all cadavers the right heart was found distended with thick, dark, coagulated blood, and the parenchyma of the lung filled with blood, which pointed to death from asphyxia.

Comparing these two tables with the recent epidemic in Hamburg, there are found some things in the recent epidemic, viz: (1) Rapid course; (2) absence of prodromal symptoms (rice-watery discharges, which resemble the epidemic of 1830; on the other hand there are others which recall that of 1847); (3) frequency of the cholera-typhoid; (4) frequency of recurrence of attacks; (5) no age was immune; children were frequently attacked.

THERAPY OF CHLOROSIS (*Wien. Klin. Woch.*, No. 50, 1891.—By Dr. Otois Pick.) In a great number of cases stomach symptoms are most prominent and unpleasant, and are often to be referred to a certain atonic state of the stomach. This sometimes leads to a dilatation, and this to a longer retention of ingesta in the stomach. These considerations suggested to

the author to treat sixteen cases of chlorosis by washing out the stomach every morning. Five of these had been treated for months with iron in vain. The result was surprising. In three to four weeks cures were effected in cases which had withstood iron treatment for months. In all the cases could be observed at the same time an increase in the quantity of hemoglobin. As some of the chlorotics would not consent to this treatment it occurred to the author to attempt a disinfection of the contents of the stomach, and he selected creosote for this purpose. He gave three times daily, immediately after meals, a capsule containing 0.05 gram of creosote, and was able to observe the same good effects as from the washing out of the stomach.

AN EXPERIMENT IN A NEW-BORN CHILD IN REGARD TO THE LOCATION OF THE RESPIRATORY CENTER (*Wien. Klin. Woch.*, No. 50, 1891.—By Prof. Kehrn.) It became necessary to perforate in a primipara. After the head was opened the brain was broken up and partly washed out, partly pressed out by the pulling of the head through the narrow opening. Contrary to expectation the child breathed after being delivered. For a quarter of an hour it took deep, regular inspirations, six to the minute. The hand and foot reflexes were present, but no spontaneous movements of extremities. On looking into the cranial cavity it was seen that all the cerebrum and most of the cerebellum was gone. Only portions of the peduncles of the cerebellum and the pons remained, but the medulla remained intact. The medulla was now cut across one centimeter above the point of the calamus scriptorius. No change occurred in respiration or reflexes. On another section being made one centimeter deeper, just at the lower end of the calamus, both respiration and reflexes ceased.

In the portion of the medulla isolated by the two sections there was contained neither the classical centers of respiration nor the roots of the important sensitive and motor nerves which have to do with respiration. One must therefore conclude that the respiratory centers lie in the same places in man as in the other mammalia which have up to the present time been used for experimentation.

J. B. BULLITT.

DR. SHLAPOBERSKI has found the caustic action of nitrate of silver in contact with iodoform, which it decomposes with a hissing noise, very efficacious in the treatment of lupus. In an obstinate case he scraped away all the large nodules and applied nitrate of silver, afterward covering the parts with collodion containing 10 per cent of iodoform. The treatment was renewed daily. In three months there was a decided improvement, and in seven months the parts were entirely healed. There has since been no recurrence though more than four years have elapsed.—*London Lancet.*

Abstracts and Selections.

CHOLERA.—In recent years, when cholera has reached Europe, it has generally come by the way of the Suez Canal. This was the case in the outbreak of 1890 in Spain. In 1891 no cases were reported in Europe. It had, however, come through the Red Sea ports into the Hedjaz during religious ceremonies in Mecca, and had spread through Asia Minor. In the first of the year cases still occurred in different parts of Asia Minor, but by the middle of February it had disappeared from the neighborhood of Damascus and Beyrout, and existed only in one or two interior valleys. This year the religious pilgrimage to Mecca was not attended by cholera.

The epidemic of this year appeared in March in the northwestern provinces of India. It is obligatory on every Hindoo to bathe in the Ganges where it issues from the mountains. The dying Hindoo also is immersed in this stream if it is possible to get him there, and this point is always considered a cholera focus. The water this year was very low, and the bathing place was reduced to a pool. On March 22d the first case occurred at Hurdwar, and on the 25th the fair was closed by the police authorities. The disease was spread by returning pilgrims through the Punjab, and reached Delhi on March 30th. From here it spread through the Cashmere Valley, and reached Afghanistan on April 15th, and it reached Persia in May. In June it crossed the Caspian Sea, and in July spread among the population of Asiatic Russia. By the middle of the month it reached the Caucasus and crossed into European Russia. It was at this time especially virulent at Teheran and Astrakhan and in the Caucasus. It advanced steadily through Russia, reaching Moscow and St. Petersburg by the middle of July. Until this time no cases had been reported west of Russia except in Paris, and these cases in Paris were not a part of the invading epidemic. From April 5th up to July 25th about one hundred and sixty deaths from a rapidly fatal diarrheal affection had been reported in the neighborhood of Paris, and the character of the disease, although attributed to the use of Seine water, and manifesting itself in those quarters where that water is supplied for consumption, bore such a striking resemblance to Asiatic cholera that its identity was during the whole summer a subject of dispute. This disease, which was popularly called cholérine, had existed as an endemic outbreak to a less extent in previous summers. In the autumn, after cases of undoubted Asiatic cholera had occurred in Northern France, the attempt to distinguish between the two diseases was abandoned.

In regard to the origin of the cholera in Hamburg, Havre, and Antwerp nothing positive is known. The infection of Hamburg may have come by rail through Germany with Russian immigrants on their way to America,

or it may have come by sea from Russia or from India. All of these suppositions were discussed. The authorities of Hamburg discovered the true character of the disease on the 22d of August, and announced it on the 24th. It was found to exist in Havre and Antwerp within a few days of the same time. During the next week isolated cases made their appearance in many cities, the cases being almost all easily traced as imported from Hamburg. Several cases occurred in Berlin, some in other North German cities, some in different English seaport towns, all of the latter being in persons directly from Hamburg. Such isolated cases continued to occur during the first half of September, diminishing in frequency. In Hamburg the epidemic increased very rapidly and with a great mortality. Although the highest point in mortality was reached in the week ending September 3d, when 4,168 deaths, of which 3,710 were from cholera, were reported, making a death-rate of 340.8, nevertheless for some time the decline was slow, but after the last week in September fell rapidly. In Havre the epidemic was not nearly so great, the number of cases a day, about the 1st of September, being from 25 to 100.

The extension of the epidemic crossed the Austrian frontier some weeks later, a few hundred cases being reported, especially in Austrian Poland. It appeared in Buda-Pesth early in November, and continued into December. In the whole Austrian Empire 1,000 cases and 500 deaths may be estimated as the number during the autumn. On November 1st Hamburg was declared free from cholera, but in November 4 deaths occurred, and in the last half of December a fresh outbreak occurred, about 40 cases being reported up to the present time. The official statistics in October gave the number of cases as about 18,000, with 7,600 deaths. In Havre the number of cases from July 15th to October 15th was given as 1,298, and that of the deaths 523. This includes a few cases which were later classed as cholera, although occurring before the outbreak was recognized. During November a few cases were reported from different parts of France, 104 in Holland, 33 in Belgium, whereas in Germany there were none except the 4 in Hamburg. In Russia the epidemic was much more serious and persistent; many districts were revisited after the epidemic had apparently declined. After the 1st of November the disease as a whole was much less serious in the Empire, but the total number of cases reported remains considerable even up to the present time. The estimate of 300,000 deaths is commonly considered as less than the actual fact. The efforts of the sanitary authorities were much hampered by popular uprisings, and in some cities serious riots occurred in consequence of the attempt to enforce sanitary regulations.

Cholera was imported into the New York quarantine directly from Hamburg. The first infected steamer to arrive, the *Normannia*, left Hamburg just before the official announcement of the existence of an epidemic. Within a week two more steamers, the *Moravia* and *Rugia*, and later the *Scandia*, reached New York thoroughly infected. The number of deaths at sea had been 63, and a still larger number were either suffering from the

disease on arrival or came down with it shortly afterward in quarantine. The number of passengers detained from this cause was very large, far beyond the capacity of the New York quarantine station. After keeping the cabin passengers, who with a few exceptions had been free from cholera, for several days upon the infected ships, a steamer was hired by private liberality to accommodate them, and Fire Island bought as a place of detention. The inadequacy of the quarantine station and the bungling of the whole matter may be understood by following the subject as it appeared from week to week in the *Journal*. A few cases, a dozen or more, with five deaths, occurred in the city. Their source is doubtful, but is more probably due to contagion introduced by passengers from an earlier steamer which sailed from Hamburg on August 14th than that it escaped from the quarantine.—*Boston Medical and Surgical Journal*.

A STUDY OF SOME OF THE DRUGS USED IN FUNCTIONAL NERVOUS DISORDERS.—Dr. Arthur A. Boyer read a paper (Massachusetts State Medical Society) on this subject. He stated that in the treatment of functional nervous disorders, as in other fields, there is a great temptation to secure rapid and striking results, and that on this account there is a disposition to give secondary consideration to the means employed, and too often to forget the rigid scrutiny to which they should be subjected. There are two things that impress the student of therapeutics as applied to functional nervous disorders: first, the necessity for pushing familiar drugs to their physiological limits; second, the large number of new drugs reported as accomplishing startling results without a sequence of dangerous or unpleasant symptoms. It is not unreasonable to suspect that such reports are based on insufficient data, and that better acquaintance with these drugs will reveal elements no less dangerous because insidious.

The first drugs referred to by Dr. Boyer were those used in chorea, and foremost among these is arsenic. There is a large class of patients who have been taking moderately small doses of arsenic, and who bear characteristic marks of their treatment. The skin is pale, often sallow to the point of muddiness, the air is languid, the gait rather uncertain, the hands moist, flesh flabby, appetite poor, habit constipated, heart's action feeble, frequently accompanied by palpitation or irregularity, pulse soft, respiration shallow. Examination of the muscular system reveals a lack of tone. In general the condition of the patient is what might be called below par. Dr. J. Hutchinson has in several of his monographs called attention to the harmful effects of long-continued use of the drug. The probable action of arsenic is two-fold: primarily, a depression of the spinal centers by reason of the poverty of the blood; in the second case, and to a much less degree, a reduction of the working power of the muscles by the direct effect of the drug.

The next drug to which the reader referred in his paper was chloral. The cases of chorea in which it has proven of most value are those of the

acute and violent form, where an immediate cessation of spasm is requisite to the safety of the patient. The theory for its use was the fact that in sleep choreic movements usually cease. Chloral was quoted as a pure hypnotic. The large amount of chloral required in such and similar cases, however, to produce sleep certainly creates a doubt in the mind whether the effect is produced through the hypnotic action of the drug so much as by the profound depression of the brain and spinal centers and direct action of the muscles themselves. Dr. Boyer also referred to the use of the antipyretics, namely, antipyrine, phenacetine and exalgine in chorea. He stated that these, as well as all other drugs that have won a reputation in the treatment of chorea, possess as their most prominent feature the power to cause a depression of sensation and motion to the point of paralysis; that in doses short of this effect they are not of much value, and that when they are administered in doses sufficient to check choreic movements, other systemic effects, such as general depletion of the forces of the body, vascular dilatation and cardiac and respiratory depression attend their specific action.

Dr. Boyer next referred to the treatment of insomnia. The drugs that have proved most efficacious in producing sleep, he said, are chloral and sulphonal. The large number of persons suffering from insomnia who find their way to the specialist demonstrates only too frequently the failure of the hypnotics to accomplish what was expected of them. They comprise two classes: those who are taking chloral and sulphonal, yet can not sleep, and those who sleep when they take the drug, but consult you for "extreme nervousness." These people have certain traits in common. The first thing that attracts your attention is the hard, set features, the fixed look, the dull, heavy eyes, often congested, the dusky pallor of the complexion, the expression of despair. The face never relaxes into a smile. The patient walks as if in a trance, and talks in an automatic manner. The mental conditions differ somewhat in chloral and sulphonal. In the former there is more excitement and irritability, in the latter more despair. In some cases trembling is observed. Chloral has also a peculiar effect on the ocular muscles, disturbing their proper relations to each other. Daily contact with patients who have been taking chloral and sulphonal for insomnia, Dr. Boyer said, has forced upon him conclusions that go far from supporting the flattering opinions commonly expressed on the subject. A large number of patients who present themselves for treatment will be found to be suffering as much from the drugs they have been taking as from the original disorder, and an absolute removal of all drugs will serve, not only to elucidate the condition, but frequently also to give much relief to the sufferer.—*Ibid.*

PYLORECTOMY.—Defontaine (*Arch. Prov. de Chir.*, July, 1892), reports a case of successful extirpation of cancer of the stomach. The patient was a woman, aged thirty-four, who had suffered for six months from flatulence and gastric pains, and for three months from occasional attacks of profuse and severe vomiting. In the operation (which was performed in April of

this year, and lasted over two hours and a half) a smooth, rounded tumor, which had contracted but few and slight adhesions with surrounding parts, was removed from the pyloric end of the stomach. After the upper half of the large opening in the walls of this viscus had been closed, the lower and still patent portion of this opening was fixed to the open end of the duodenum by two rows of sutures, one row uniting the edges of the mucous membranes, the other the edges of the serous coats. The author attributes much importance to his method of stitching the divided coats together. He applies what is called a segmented spiroidal continuous suture. This consists in a series of short continuous sutures interrupted after every five or six stitches. The continuous is preferred to the interrupted suture on account of its being more readily applied, and thus lessening the duration and severity of the operation. The subject of this case made a speedy and good recovery. She was able to leave her bed on the eighteenth day, and on the twenty-sixth seemed to be quite well. The paper concludes with the following summary of the author's views concerning pylorotomy: (1) It is an operation which undoubtedly holds the first place from a surgical point of view in the treatment of cancer of the stomach; (2) it is suitable in cases of gastric cancer with slight adhesions, which condition, however, is unfortunately but seldom met with when surgical aid is first called in; (3) when it can not be performed under favorable conditions the surgeon should fall back on the operation of gastro-enterostomy; (4) operative treatment is the only means of contending against a disease so frequent and formidable as gastric cancer, and therefore it should be resorted to in good time and with boldness, those cases being rejected in which the patients are decidedly cachectic and the disease too far advanced for any surgical interference.—*British Medical Journal*.

SPONTANEOUS CURE OF COMPLETE SENILE CATARACT. — Mitvalsky (*Centralbl. f. Augenheilk*, October, 1892,) collects all the published cases which seem well authenticated. These number eighteen, to which he adds notes of two cases recently under his own observation. As all these cases have been reported within a comparatively short time Mitvalsky concludes that the spontaneous disappearance of senile cataract is not so uncommon as has been generally supposed. The changes which occur appear to be, in most instances, degeneration of the cortical layers of the opaque lens into a milky fluid, that is the formation of a so-called Morgagnian cataract; this fluid cortex then becomes absorbed, leaving a shrunken capsule containing a hard nucleus of varying size, which sinks to the bottom of the sac of the capsule. In other cases the fluid cortex becomes nearly all or quite clear, and contains the opaque nucleus, which is freely movable within the capsule. Sooner or later this clear, thin cortex undergoes absorption. In a considerable proportion (6 out of 20) of the cases the changes in the cataractous lenses have begun after an attack of glaucoma. *Ibid.*

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D. W. VANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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THE ADVANCEMENT OF SURGERY.

In reading The Lancet's *Annus Medicus*, 1892, wherein nineteen pages are needed to set forth the year's progress in medical science, one is surprised to note that a half page is more than sufficient for the record of the advancement of surgery.

This seemingly meager showing is, however, by no means to the discredit of this great department of the healing art, but is really to its credit, since it indicates that surgery in its wonderful forward movement during recent past years has taken or is about to take its place among the exact sciences. Since the increment of bacteriology and the sublime results following its ways and means of dealing with germs surgery has levied little from the collateral sciences. Increased skill in the technic of her art and new devices in her mechanical features may be looked for so long as men of the inventive turn essay surgical work; but novelties and surprises, such as characterize her splendid period of recent development and such as now characterize the more tentative branches of medicine, may no longer be looked for in surgery.

Nevertheless no lover of his art can fail to read with pride if not with emotion The Lancet's brief comment upon the doings of surgery for the year of grace past:

The year that is just closing has not been marked by any epoch-making discovery or advance in surgery. But it would be idle to deny that surgery is a steadily advancing art and science, and that each year some gains are

to be reckoned. When the history of surgery in the nineteenth century comes to be written, the latter half will be seen to be the period of the greatest progress attained since the art was first practiced. Surgical pathology has been revolutionized and surgical therapeutics have been to a large extent established upon a true scientific basis. Surgery has become at once more successful and more responsible. Our ability to control results has added a new weight to those borne by our predecessors. They when met by failure and disaster, could only shrug their shoulders and appeal to Providence. We, however, know that such failure is generally to be traced to some error of omission or commission of our own. In all branches surgery is becoming more and more exact, and the old rough and inexact methods will soon be as extinct as the dodo. For an acute abscess lancet and poultice are now not used, but the aseptic knife and careful antiseptic dressing. For a boil or carbuncle the old-fashioned crucial incision has been relinquished, being replaced by the removal of all the infective slough and tissue; and so through all the range of operative surgery. Thus excision of joints is replaced to a very large extent by arthroectomy. In operating for cancer of the breast it has been shown that it is very important to remove the entire gland, including all outlying nodules, the fascia over the pectoralis major muscle, the axillary lymphatic glands, and the strand of tissue containing the lymphatic vessels passing from the breast to the glands. This is not empirical, but the result of painstaking pathological investigation and demonstration. The enucleation of tumors of the thyroid body is becoming more generally recognized as preferable to the drainage of cysts, the scraping out of soft tumors or excision of a part or the whole of the thyroid gland. This is a distinct advance. Again, the practice of applying a ligature to the main artery close above an aneurism has been practiced of late with great success. Such an operation, when conducted without infection of the wound, is shown to be unattended with the risks previously associated with it, and to be free from some of the disadvantages, such as recurrence of the pulsation, which belong to the Hunterian operation. Less and less is heard of the treatment of aneurism by compression, as surgeons' confidence in their ability to conduct an aseptic ligature of an artery has increased. In abdominal surgery much is being done to place the treatment of disease and injuries of the stomach and intestines upon the same satisfactory footing as that of diseases of the ovary. If the success has not been all to be desired, it is nevertheless highly encouraging. Lumbar colotomy is fast giving place to the inguinal operation, and excision of the rectum is established as an effective operation. In the practice of asepsis two things are forcing themselves more and more on surgeons' notice: the danger of infection through the organisms contained in the skin of the patient and on the surgeon's instruments and fingers, and the little risk of infection through the air. Much greater attention is paid to the cleansing of the patient's and the surgeon's skin, and more efficient means are used for the thorough cleansing of surgical

instruments. Heat is the most trustworthy antiseptic, and instruments are now commonly sterilized by dry or moist heat, the simplest and best means of all being to boil them for a short time in a one-per-cent solution of bicarbonate of soda; this appears to be fatal to every bacterium and spore.

Notes and Queries.

THE JEWISH SHECHITA.—The Jewish method of slaughtering animals forms the basis of a great politico-humanitarian controversy in Switzerland, where it has been forbidden in the cantons of Berne and Aargau. The Society for the Prevention of Cruelty to Animals characterizes the method as cruel, and contrary to all laws of humanity, while the Jews look upon the movement as more an anti-Jewish one than one based on any real humanitarian principles. It is looked upon as a violation of the constitutional guarantee, and what they ask for is protection of their liberty of conscience, as the 50th Article of the Federal Constitution guarantees the "free exercise of worship within such limits as are compatible with public order and good morals." Their advocates point out that those people who clamor against the cruelty of their method of killing animals, in which the animals suffer pain for a few seconds only, are deaf to the squeals of pigs being killed, which squeals continue as long as a half hour sometimes before they are hushed by death. The pangs of the hunted stag, the pain inflicted on birds wounded and not killed outright in sport, the thousands of animals tortured yearly by castration to render their flesh palatable to man, are all instanced as far more cruel, and yet allowed to continue without being condemned. It is difficult for them to comprehend why the custom should be prohibited in these two Swiss cantons alone, while the Jews in every other part of the world are allowed to practice the same without interference. The German Reichstag had the matter under consideration in 1887, and saw no reason to interfere with the custom, which was, and still is, in vogue among the Jewish community in that country; and in America the question of universal adoption of the method by people of all creeds has been raised on hygienic grounds.

The Jewish authorities in Switzerland have obtained the opinions of a large number of distinguished physiologists and veterinary surgeons on this question, and these are unanimous in their belief that the Jewish method of slaughtering animals is not more cruel than any other; some, indeed, considered it less so. Certain physiologists have further urged in its favor the hygienic properties of the meat, which, deprived of that factor so prone to decomposition—the blood—keeps longer, and can, they consider, be better dealt with by the stomach and other organs of digestion. It is further

urged that the excretive materials contained in the blood rapidly give rise to chemical changes resulting in the production of toxic ptomaines, which, by their repeated action, injure the constitution. The Jewish law forbids the people to eat any other but the bloodless flesh of animals which have been killed by their method of cutting the throat, in which a single gash divides the carotid arteries and jugular veins. It is also necessary that no extra lesion should be produced in killing the animal, otherwise its flesh becomes "tripha," and therefore forbidden to be eaten by Jews. The difficulty of meeting both these requirements by any other method than that which has been employed by them for thousands of years, and which is spoken of in the Pentateuch and in the Talmud, is very great; but the problem deserves close attention, and leads to the consideration of what bloodless methods of painless killing can be offered as substitutes for that which has been forbidden in Berne and Aargau. There can be no doubt that a blow on the head, if sufficiently severe, causes instant loss of consciousness, in proof of which may be adduced the fact that persons who have thus been rendered unconscious have no recollection whatever of the blow when consciousness returns. But the tremendous fall of blood pressure which follows such a blow would probably preclude the possibility of the animal being made bloodless, besides which the blow would in all probability produce an external lesion in most cases.

The only other method of painless killing is that in which anesthetics are employed. An objection which the Chief Rabbi in this country, Dr. Adler, has raised to this is the impossibility of being certain that the animal is in the enjoyment of full vitality and perfect health at the time of killing. The use of ether is excluded, owing to its causing rapid decomposition of the meat. Chloroform and carbonic acid are both admissible as far as this point is concerned, but against the practicability of their employment are the difficulties which would attend their administration and the tremendous cost. Moreover, it could not be guaranteed that the animal would not die from shock or from the anesthetic.—*British Medical Journal*.

Editors of the American Practitioner and News:

GENTLEMEN: Permit me to say, through your journal, that I think it should be beneath the dignity of any medical society to allow the publication by the secular press of the papers read at its meetings, or the discussions that follow, for the simple reason that those papers and discussions are not understood by the public, and can not be of service either to the public or profession, but are calculated to lower the standing of the profession in public esteem. I think it far better for any gentleman known as a doctor of medicine, who may wish to bring to himself notoriety through the secular papers, to address his articles to the editors of such papers in place of first reading them before a medical society, for in so doing he secures to himself all the honor attached, and at the same time protects the medical profession from any reflection which may result from a misunderstanding

of his paper by the public. All reasonable gentlemen in the profession, who are possessed of a fair amount of intelligence, are able to understand each other's differences of opinion, and concede the right each one to the other without desire to cast any reflection because of such difference of opinion; but the public does not understand how doctors can differ and at the same time be successful in their professional work without disastrous results to their patients.

The publication by the secular press of papers read and discussed before medical societies can never enable the public to understand and appreciate the fact that by the expression of difference of opinion is due all the advance medical science has ever made; for, if opinions were never expressed, differences would never be known, but investigation in medical science would be as unspoken and equally as worthless to suffering humanity as the creeping mole that lives in the ground. So, if a doctor reads a paper before a medical society, whether it is discussed or not, to say the least it becomes unprofessional to allow its publication anywhere except in a medical journal.

J. FULTON PURDOM, M. D.

LOUISVILLE, KY.

CANCER COCCIDIA.—The paper on Cancer and its Parasites, by Prof. Metschnikoff, which we publish to-day, is interesting from many points of view. Those even who maintain that cancer can not possibly be due to a specific parasite must admit that the researches made lately both in France and in this country have rendered it probable that parasites always do occur in cancerous tumors. The paper in question is especially important from the fact that it puts on record the opinions of a zoologist well acquainted with other forms of tumors in which the presence of parasites has been undoubtedly proven. Prof. Metschnikoff now states as his opinion, that parasites having the greatest analogy with coccidia are found in human tumors also. This eminent observer bases his opinion not on his own observations only, but on the microscopical specimens of Soudakewitch and Ruffer, whose preparations he had an opportunity of seeing. It is a noticeable fact, however, that since this paper was written (September, 1892,) a further stage in the life-history of the parasite has been described by the English observer in the *British Medical Journal* (November 5, 1892), who has traced the development of these parasites in the nucleus of the cancer cell. The supposition that cells formed by endogenous multiplication had been mistaken for parasites—and this had undoubtedly taken place in the earlier observations on the subject—had already been controverted by Ruffer; and it is clear that such a mistake is impossible whenever observers make use of more refined methods of investigation. Another noteworthy fact about these new investigations is that they bear out former clinical observations, for, as Metschnikoff points out, there are hardly any grounds for supposing that cancer is a contagious disease, whereas there is strong clinical evidence to show that cancer, like other coccidial diseases, is

of miasmatic origin. With regard to the formation of spores, or to the mode of reproduction of these organisms, Metschnikoff can give no clue, and it would appear that these organisms reproduce themselves outside the body only, for the structures which have been described as spores by the Russian observers have by no means the definite characteristics always present in true spores. We would appear for the moment to have come to the end of what can be learned by simple microscopical examination; and it is clear that further experimentation must be conducted on new principles, for that fresh human cancer is harmless to animals has been abundantly proved. Whether the cancer organisms, however, which have had an opportunity of multiplying outside the body will prove equally harmless is a question on which no one can possibly give a definite opinion at present. *British Medical Journal.*

DEATHS IN THE PROFESSION ABROAD.—Among the members of the medical profession in foreign countries who have recently passed away are Dr. Alois Aitenberger, formerly Dean of the Doctoren-Collegium of the Medical Faculty of the University of Vienna, aged eighty-three; Dr. N. P. Manssuroff, Emeritus Professor of Diseases of the Skin and Syphilis in the University of Moscow, a chair which he had occupied for thirty years; and Dr. Franz Lenk, private physician to Prince Schwarzenberg, and a practitioner of high repute in Vienna, aged eighty-seven.

Special Notices.

Notwithstanding the large number of Hypophosphites on the market, it is quite difficult to obtain a uniform and reliable syrup. "Robinson's" is a highly elegant preparation, and possesses an advantage over some others, in that it holds the various salts, including Iron, Quinine, and Strychnine, etc., in perfect solution, and is not liable to the formation of fungous growths.

IMPURE BROMIDES.—Helbing's Pharmacological Record has an important statement concerning the undue proportions of potassium chlorate that are found in the bromides. An examination made by Helbing and Passmore show that it is a serious matter to buy the potash salt at the present time without having it carefully analyzed as to the percentage of chlorides it may contain. The importance of purity in a drug of this nature is very great, and will receive the earnest heed of neurologists everywhere.—*Journal American Medical Association.*

[Peacock's Bromides are of known purity, and should be used when bromides are indicated, as they are the *only* preparation of *Chemically Pure* Bromides on the market.]

A UTERINE TONIC.—There are medicines that act specifically upon the uterus. Notably among these are Viburnum Prunifolium, Cohosh, Skullcap, and Aletris, all of which are active ingredients of Dioiviburnia, in which are combined also anti-spasmodic and tonics that render it efficient in all menstrual disorders. Try Dioiviburnia in uterine diseases.

THE AMERICAN PRACTITIONER AND NEWS

"*NEC TENUI PENNĀ.*"

VOL. XV.

LOUISVILLE, KY., FEBRUARY 25, 1893.

No. 4.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—*RUSKIN.*

Original Articles.

TREATMENT OF SYPHILIS.*

BY ALBERT MUENCH, PH. G., M. D.

Gentlemen, I wish to speak to you on the proper way of treating syphilis, a disease that is not localized to any particular climate, that is not confined to any particular class of society; you will find it from the prince to the pauper, and among every nation. It spares neither the infant nor the gray-haired, it has no respect for the weak or the strong, and the innocent as well as the vicious become the victims of its terrible influence; and all of you, let you be what you may, general practitioners or specialists, are forced to meet it, and, in whatever light you may choose to regard it, it is your duty as physicians to recognize it, and with those means which are fortunately at our command to treat and destroy it.

It is customary to speak of the local phenomena resulting directly from the contagion as primary symptoms, and those which follow when the whole blood is poisoned as secondary or constitutional, and of those which may appear at various periods after the primary and secondary have long cleared away as tertiary.

I will commence by treating the primary lesion, and would say, do not treat the primary lesion by the use of strong caustics. Always bear in mind that absolute cleanliness is the true foundation of all treatment; and my experience has been that the primary lesion of syphilis needed but little treatment in the majority of cases beyond keeping the part

*Read before the Falls City Medical Society, February 9, 1893.

dry and clean, as its natural course, without there are complications, is toward spontaneous disappearance.

When there is any tendency to ulceration in the lesion, by burning the parts vigorously you only cause the inflammatory areola to break down in ulceration at a later period. In most cases you will find that a chancre that has not been burned and is kept clean will show no tendency to become inflamed. In the majority of cases where you find it inflamed it will be from the lack of cleanliness, or, on the other hand, the unnecessary use of some salve or soap, lead-water, lime-water, or the black or yellow wash which produces a reddened and angry condition of both the chancre and the surrounding parts.

The very best remedy to use for the primary lesion of syphilis that I know of is iodoform, and there can be no doubt as to its beneficial effect, and you get that in the pleasantest form under the name of Merck's iodoform, which has the reputation of always remaining in a fine powder. Lehn and Fink make a fine iodoform, known as Lehn and Fink's rewashed iodoform, which is useful in the treatment of chancre.

Since the pungent and undisguisable odor of iodoform is such a decided objection to its employment in private practice, I wish to give you a point in this direction. We hear a good many patients say, "Doctor, please don't use iodoform, because it has a bad odor and will be smelled by everybody." If you use iodoform carefully and in small quantities people will not be able to detect its presence. In other words, when you are dressing a chancre with iodoform be careful that the iodoform does not get on the clothes of the patient, as that alone will cause the patient to smell of iodoform for weeks; put on only sufficient to cover the sore, place a piece of cotton over that, and then draw the prepuce over the cotton. Now there are other remedies that you may use, such as iodol, aristol, salol, euophen, dermatol, chemically known as subgallate of bismuth, bromonol, and peraseptol; but none of these are as good as iodoform.

Now, gentlemen, you will find that you can get good results from any of these remedies that I have mentioned, but the point that I wish to impress upon you to-night is, do not follow one of the earliest rules respecting the treatment of venereal diseases, which is as follows, Cauterize every suspicious sore. And I hope you will assist in changing this rule to, Do not as a rule cauterize any suspicious sore.

There are times when you will find the chancre lumpy and a good deal of hardness present. In such a case I can recommend to wash the

parts first with soap and water and then with a five-per-cent carbolic-acid solution, dressing it with blue ointment.

You will find that there is a good deal in the way you tell patients that they have syphilis, as to the time they will remain under your care. It is your duty to make the unpleasant fact known to them as gently as you can, but at the same time with all the seriousness that the case demands.

The physician's duty does not end, and is not simply to treat the individual case, but he must do all in his power to prevent the transmission of the disease to others by the various ways besides sexual intercourse.

How frequently do we see the primary lesion on the lips from kissing, the use of drinking-vessels, pipes, etc. ; and, as recently reported in a New York journal, where a brother infected his innocent sister with syphilis by giving her a piece of the same candy he had in his mouth. It would be better for the community if every young man knew how easy it is to become infected with this disease, and how difficult to be cured.

In the next place it is your duty to impress upon the mind of the patient that a cure does not depend upon the amount of medicine taken, but upon the duration of the treatment, and that time is as essential to the cure of syphilis as to the growth of a tree. As the disease is a slow one, and the treatment is a matter of years, impress upon the patient the necessity of remaining under treatment for the next three years at least. Two years and a half of continual treatment and six months' watching to see if all is right, and in the majority of cases you will find, if your patients start in with a good constitution, they will come out cured in that time. There are some cases, however, that will act badly, but by care and attention, and with the knowledge of the proper remedial agents you will be able to tide them over their trouble in time. But, as I say, there are cases in which even with the best of care and attention, the disease seems to get the better of them and obtain complete mastery for a long period of time.

Now, gentlemen, what you want to bear in mind is, that syphilis is a constitutional disease, having a tendency to lower the vital powers and develop certain lesions which may be the means of producing invalidism in your patient, and perhaps death. It behooves people, therefore, who have syphilis to take the best of care of themselves, and keep their health up to the highest possible standard of development.

In treating patients with syphilis put them into as good a mental and physical condition as possible, for bear in mind this one fact, that the effect of the mind on the malignity of syphilis is very great indeed. Your patients should not draw upon their vital forces; if they worry and bother themselves about their business, about their finances, about their disease, and so on, while under the influence of syphilitic infection, you can well understand that the strain upon their nervous system is going to do them harm, and your treatment of their cases by the therapeutical measures at your command will not result in much practical benefit to the patient.

Mercury and iodide of potash are very essential, and that they are the backbone of the treatment of syphilis can not be disputed; but at the same time the points that I have mentioned must be taken into consideration if you wish to treat your patients successfully.

Having imparted a necessary amount of information, it is your duty to give advice as to the habits of life. The diet needs little modification. Smoking is, however, to be forbidden, and tobacco in any form, for, if you have no oral lesions, the excessive use of tobacco is very apt to produce their appearance. Late hours, overwork, excitement, anxiety, intemperate habits, and every thing that depresses the mind or exhausts the body must be stopped. Now, as to drinking, if your patient be a drinking man, try to persuade him to stop the habit; but to my mind I hardly think it necessary to teach him prohibition doctrines.

Now, as to the administration of mercury, you will find no routine way of giving this drug, as every case of syphilis, let it be in male or female, young or old, is a law unto itself, and a dose that affects one patient favorably will affect another unfavorably, the dose which will remove the poison in one patient will prove utterly powerless in another. So, if a patient were to come to you with the first manifestations of syphilis, you should not give iodide of potash, for this drug is contra-indicated in the earlier stage of syphilis, except there be some severe trouble of the brain or periosteum.

The proper way to treat such a patient would be to give a pill of the proto-iodide of mercury, for of all preparations of mercury for internal use the proto-iodide is the best, and the best pill I find on the market is that of W. H. Schieffelin & Co., which I am using altogether, as I notice it may be given for a long period without causing gastric disturbance. The proto-iodide is useful for all the forms and stages for

which a mercurial is indicated, but is not as reliable as inunctions when a rapid effect is required.

I find there is no necessity for the use of any tonic in some cases, though in a good many patients you will find it very essential. The best tonic I know of is cod-liver oil, and you will find it an inestimable remedy in the treatment of certain forms of syphilis, for instance, when you have an ugly pustular form of eruption, and cervical glands may inflame and form indolent abscesses or ulcerations which you will find will not readily heal. If a course of cod-liver oil is ordered before or preferably, as I do, in connection with the administration of mercury, these obstinate cases of syphilis may be brought under control. Bumstead recommends cod-liver oil as a vehicle for the bichloride of mercury, which has first been dissolved in a few drops of sulphuric ether, which is very valuable. I use a great quantity of cod-liver oil in the way of an emulsion, and give directions to the pharmacist to prepare it fresh each time, as this is the only way to get good results from emulsions of cod-liver oil. This emulsion contains fifty per cent pure Norwegian cod-liver oil and the hypophosphites of soda and lime, and the emulsion must be prepared with best gum arabic.

As another excellent tonic I can recommend the following:

Hydrarg. proto-iodide, grs. xxiv;
Ferri et quinine citrate, drs. v;
Ext. hyoscyamus, grs. xviii.
M., ft. pill no. c. Sig: Three a day.

If under the use of the mercury alone, or in combination, the glands are going down, the remedy is surely doing your patient good, and you must keep your patient under this treatment for a month at least, and watch the patient closely; but should you notice the remedy not to act properly and your patient not showing any signs of improvement under its use, then you can increase the dose of mercury to be given each time by increasing the number of pills.

I seldom ever give more than three grains of proto-iodide of mercury a day, and four grains will be the maximum amount you should give in twenty-four hours, for if you do not produce the desired effect with that amount you are not going to produce it at all.

At the onset you must increase your dose of mercury until you get your patient regulated. I usually inquire of them how the mercury

has acted, how they are feeling, whether they are losing or gaining in weight, whether their thoughts are as clear and capable of the same amount of mental effort as before the onset of the disease, and these points will be a guide for you in your medication of the patient.

The mouth, you will find, will often become irritated by defect in it, and the mercury will be well borne and produce its physiological effects if you keep the mouth in a good state. After the use of mercury for two or three weeks you will observe the condition of the gums, and if you find any trouble there touch them with some tincture of iodine and keep up the use of the mercury. It has always been a good plan to make peace with the mouth under all circumstances. So, when a patient comes to you with syphilis, send him at once to a dentist, and have his teeth cleaned and mouth put into good condition and it will save you as well as the patient a good deal of trouble.

Dr. Bulkley, of the New York Hospital, called my attention to a well-marked indurated chancre on the index finger of a dentist, produced by a scratch from a patient's tooth, and the abrasion, coming in contact with an oral lesion, infected the dentist with syphilis. For this reason I think it well to protect the dentist by calling his attention to the condition of the patient.

The best test that we have of the efficiency of the mercurial treatment is the rapidity with which the lesions of syphilis vanish. You will find that every day during the first year of syphilis is a matter of considerable importance, for during this time the disease is more amenable to treatment than any other period of its history, consequently I keep my patients for the first six months under the use of mercury as persistently and constantly as possible; and I assure you, gentlemen, if you do this you are going to cure your patients more efficiently than by giving them an interval of rest each month.

You must keep your patient continuously under observation and treatment, but at the same time bear in mind that there is a limit to the use of all preparations of mercury. If you give the proto-iodide for the first month or two, and all is well, why then keep it up; but if you notice no effect, why then change to some other preparation of mercury.

I wish to say a few words in regard to the pill *hydrargyri* or blue pill, and I just mention it to condemn it. You will find that the blue pill is about as uncertain a remedy as you can use in syphilis. It is one of those drugs that you do not know how it is going to act.

It may be convenient to introduce here a few details as to the differ-

ent methods of using mercury for the cure of syphilis, other than the internal use, such as inunction, fumigation, and hypodermically.

You will find the inunction treatment specially indicated in all cases where rapid effect is desired, as in syphilis of the eye, nervous system, brain, soft palate, or larynx. The only objection I find to its use in general, in preference to other modes of administration, is that it is not so cleanly.

The preparations employed for inunction treatment are blue ointment and the oleate of mercury. Although the latter is cleaner to use, I prefer the blue ointment, as it acts more favorably against the syphilitic virus.

If you use blue ointment, take thirty, forty, or fifty grains of the ointment for one inunction—and it should be rubbed in gently but firmly for ten or fifteen minutes. The inunctions are to be made each night on retiring; first night, one or both inner or posterior surface of the calves; second night, both thighs, inner surface; third night, abdomen and sides of thorax, including the axilla and nipple region; fourth night, back; fifth night, both arms, and so on, each time previously washing the parts before applying the ointment. It is necessary to bring the mercury in contact with the whole body. In this way you are destroying those small cells which develop in the skin, and you are at the same time permeating the skin with the mercury, which is producing its effect on the glands. As far as we understand syphilis we know that it commences around the blood-vessels in its permeation through the system, and that the lymphatics are its chief channels of distribution, consequently it is always well to act on the glands whenever you can.

If during the rubbing you notice any irritation over the part, cover it with Lasarr's paste, which is two parts starch, two parts oxide of zinc, four parts vaseline, to which I sometimes add carbolic acid. In that way you will keep down the dermatitis. It does not take more than seven or eight rubbings to cover the entire skin, but this must be done faithfully and intelligently.

Having gone over the whole body, it is well to give the patients a rest for three or four nights, and while they are taking the inunction it is well to ask them how they are feeling, if they have a diarrhea, pain in the stomach, do they sleep well at night, are they nervous or depressed. If they answer no to your questions, then you know that you are treating your patients for syphilis efficiently.

You must continue with your inunctions until you have given your patients forty or fifty rubbings, and as a general thing thirty-five or forty grains of mercurial ointment will be sufficient. The best law regulating the amount of mercurial ointment you use in a given case will be your own judgment, but if your patient be a poor, weak individual, twenty-five grains of the mercurial will be enough. Then, again, if your patient be a robust, vigorous individual it may require as much as sixty grains. While using the inunction treatment you can use the stomach for tonic treatment.

I always impress upon my patients with syphilis the necessity for rest and recreation. During the summer I have them go away to the country as long as possible, and as a very valuable aid to their treatment I have them to take very hot baths in order to produce free diaphoresis. I recommend my patients to a bath house where they have as good and as fine facilities for Turkish baths as can be found. I have them to take these Turkish baths, as they stimulate the circulation and produce diaphoresis in a way that seems to scatter the mercurial throughout the system.

Whenever I use the oleate of mercury I use the twenty-per-cent solution, and dilute with two parts of vaseline, and use fifty to sixty grains for single inunction. If the oleate is employed it can be rubbed into the soles of the feet, especially in children, or in adults where the skin is thinnest, as in the flexures and over the ribs.

Another method of using mercury is by the fumigating bath; but this is troublesome and difficult to carry out properly. In hospitals I have seen it used to some advantage where they have the necessary apparatus at hand and good attendants.

The method is as follows: The patient is made to sit over a lamp upon which from twenty to thirty grains of calomel have been placed; the calomel is sublimed by heat in company with watery vapor, and is deposited on the patient's skin. When the process is completed the patient is made to wrap in a flannel gown, and without any washing or drying to go at once to bed. In using the fumigating process it is well to see that the calomel is specially prepared and of great purity.

As to the treatment by the injections of mercury, all you need is an ordinary hypodermic syringe. Keep it in the cleanest possible condition, cleanse the surface of the body you are going to inject, and then inject into the muscle one sixth, one eighth, or one twelfth of a grain of bichloride of mercury in twenty minims of water, and in that way where

the stomach fails, where the injunctions are inadmissible, you will find that you have a remedy which will not disturb the stomach, and which will affect the syphilitic infection favorably.

As to the treatment of the tertiary lesions, gummatous formations, affections of the bones, nervous system, and internal organs, iodide of potash is the remedy. Even in these cases its use should not be long continued without giving a mercurial also, and the iodide should be given after meals and in large quantities of water, and for two or three weeks after disappearance of all lesions.

Now, to sum up the treatment, I would say, push on for the first year the mercurials, giving the patient several weeks' rest after the first six months, and then at the end of the first year you can use the combination of iodide of potash, or the so-called mixed treatment, or use the iodide and the mercury separate. Push the treatment in the second year, and then use the large doses of the iodide, and your patient will be cured. In the vast majority of cases you will have the best results by following such a treatment as I have here given you in case of syphilitic infection.

LOUISVILLE.

A FEW THINGS TO BE CONSIDERED IN CASES OF ALLEGED INSANITY.

BY R. A. PRICHARD.

The State assumes that every person of sound mind is acquainted with the law. The head of government is forced to the assumption through the fact that otherwise an accused individual might successfully plead ignorance of the law. There are in every community a few persons so demented that they can not understand the law; therefore they are exempt from its penalties. Such individuals are idiotic or insane. Inasmuch as the idiotic are not variable, but constantly in a weak state of mind, and everybody recognizes the dementia, an idiot is never tried for committing a crime, though idiots often commit murder, commit arson, and offer insults.

An insane person often has lucid intervals, or is mentally deranged on a single topic or series of related topics, therefore all of his acquaintances and fellow-men do not discover the mental unsoundness, hence the question arises whether a prisoner alleged to be insane is guilty or

not; that is, whether the accused has memory and understanding sufficient to appreciate the exaction of the law, to know the difference between good and bad, right and wrong, so far as the question at issue is concerned.

An accused person may understand the law pertaining to property, and therefore know it to be wrong to steal, but he might not know it was wrong to burn a school-house or a church, for he might be impelled to the burning through an erroneous notion that the teaching inside the house was injurious to the community. The man doing such burning under such circumstances thinks he is doing right, but he does not know, on account of delusion, the right and the wrong as rational people do. He is in regard to the arson insane, and therefore not amenable to the law.

A man in a violent fit of anger is partially demented for the time being, and does what he would not do in his normal state of mind; but he is not so far demented, in my judgment, as not to know wrong from right, even in regard to the object he is excited about, consequently an angry man is not exempt from the demands of the law.

A man wild through the effects of alcoholic stimulants may imagine a fiend is doing him harm, and feel partially justified in the infliction of violence, yet he still knows enough to know that he is half crazy, and will acknowledge as much to a person he respects. Such a man then is to be held responsible for his deeds. To release him would be an unsafe precedent; it would be placing a premium on drunkards. Besides, a man in the habit of drinking learns the effect alcohol has upon his mind. If it makes him fiendish he is acquainted with the fact, and appreciates it while the liquor is going to his mouth; therefore, if not fully responsible for a criminal act when it was committed, he is to be held responsible for not ceasing to bewilder his excitable mind when he felt the delirium coming on and was conscious of consequences.

A man may feel aggrieved over a question for years, and gradually persuade himself that the sentiment of the community is against him, that courts and juries will not do him justice, that to obtain equity he must take the law into his own hands and execute it summarily, and while so thinking and acting he may commit murder; then is he responsible for the deed? I think not.

The deranged mental state came on almost imperceptibly either to himself or his friends. He believed he was being injured, and was sincere in the opinion that the ordinary tribunals were so thoroughly

against him that he could not obtain justice in them. He had been educated in the legitimacy of self-defense, and applied it to the case uppermost in his mind. According to his reasoning it was no more nor less his right, to protect his interests, to murder the man that had been seriously injuring him without the least hope of redress in the law.

A man in such a state of mind committing murder is not responsible for the act, and should be acquitted when tried for the deed. But it is urged by the prosecution that he concealed the body and tried to make his escape, hence he was conscious of having done wrong, and, knowing right from wrong, was consequently guilty. However, is the sequence logical? After the murder had been committed the illusion was at an end. The exciting cause was removed, and a new state of things existed. The accused is not an idiot. That dead body calls to mind that this prejudiced community will catch him and deal with him more severely than it would with any other murderer, therefore to escape this implacable wrath he is impelled to secrete the *corpus delictu* and hasten where he is unknown.

Is the concealment proof of a stricken conscience? No, but of intelligence enough to comprehend the situation and to flee from prejudiced and unreasonable neighbors. While fleeing he believes he was right in striking the fatal blow, and is conscious of impending personal violence if he be caught. He feels that his acquaintances will be unjust and revengeful enough to inflict punishment upon him.

In the consideration of such cases it is to be borne in mind that this reticent revenge which has rankled for years has made the avenger nervous, sleepless, appetiteless, and generally restless. The feeling has depressed his spirits and disordered every bodily function. He may be conscious of eccentricity, and talk well at times to conceal his cherished opinions and studied intentions. The fact that the man trades well and expresses sound ideas upon topics in general does not argue that the old grudge and prejudice are the less profound.

The man is not wholly insane and irresponsible; he is, in short, mentally deranged on the topic that led him to commit murder, and should not be held responsible for the act. The community at large may say that he is likely to entertain similar prejudices against other people, and murder them when occasion occurs, the force of the argument being that the alleged murderer should be hung to keep him from harming others. The answer to this is that the individual under consideration is dangerously insane, and should be incarcerated in an asylum to prevent other homicides.

Reports of Societies.

NEW YORK ACADEMY OF MEDICINE.—SECTION ON ORTHOPEDIC SURGERY.

Stated Meeting, December 16, 1892, Henry Ling Taylor, M. D., Chairman.

Dr. Royal Whitman exhibited for Dr. Townsend a case of congenital club-foot, which was interesting because there was so much more varus than equinus present. Apparently the club-foot was originally not very severe, but having been entirely untreated there had been a moderate increase in the deformity, with atrophy of the foot. The deformity would probably yield easily under forcible correction with division of the tendons.

Dr. Halsted Myers said the case was a good illustration of the fact that when one corrects the varus the equinus becomes more prominent; in other words, that when the foot is in the position which it occupies in this boy, with the toes flexed and the foot adducted, the equinus does not appear so great as it really is.

Dr. A. B. Judson commented upon the remarkable development of the calf muscles in view of the fact that he had gone so long a time untreated. He thought that if the foot could be held around mechanically, so that the callosities on the outer border would disappear, the boy would probably walk with greater facility.

The Chairman said that the doubling under of the outer toes and the falling together of the anterior part of the foot were rather unusual features. In his opinion mechanical treatment would be sufficient to reduce the deformity without a resort to cutting operations.

Dr. R. H. Sayre exhibited a case of Pott's disease in a young girl whom he had seen yesterday for the first time. The case at first sight looked like one of ordinary lateral curvature, and indeed, not long ago, according to the mother's statement, this was the diagnosis made at one of the orthopedic institutions in this city; but closer investigation showed a kyphos at the sixth dorsal vertebra. Six months ago she fell out of a hammock and struck on the left side. Three months later she began to have pain under the sixth rib in the left mammary line whenever the heels struck the ground forcibly, or when she was jolted in the

cars, or when coughing or hiccoughing. The mother thinks this "knuckle" in the back was not so prominent at the time the diagnosis of lateral curvature was made. In most cases of Pott's disease the diagnosis is reasonably clear, but occasionally one meets with a case like this one, in which two or three very critical examinations are necessary before a positive diagnosis can be made.

Dr. V. P. Gibney presented a boy, fourteen years of age, as an illustration of the effect of overcorrection in congenital club-foot. He first came to the Hospital for Ruptured and Crippled when quite a baby, and was treated according to the plan then in vogue, with a side splint bandaged to the outer side of the foot and leg, with the object of favoring extension of the foot. About one year later the tendo-Achillis was divided in order to overcome the varus. He was not seen again until four or five years ago, when he showed a slight relapse, there being some shortening of the tendo-Achillis and plantar fascia, and a disposition to walk on the outer side of the foot. Under an anesthetic the foot was twisted into an overcorrected position, and plaster of Paris applied and allowed to remain on for some months, when it was necessary to repeat the operation. The heel-cord and the plantar fascia were operated upon at the same time. He was not seen after this operation until a week or two ago, when he returned, complaining of a feeling of fatigue on walking and of slight pain in the metatarsus. Examination showed the tendo-Achillis to be lengthened, and a moderate degree of flat-foot to be present. This case, and the one recently presented by Whitman, showed the fallacy of the prevailing opinion that it is hardly possible to overcorrect a case of club-foot.

Dr. Sayre did not think that the patient had a flat-foot, but a decided valgus, with marked shortening of the peroneal tendons. It looked to him as if the arch had not been sufficiently lengthened, and that too long a splice had been made in the the tendo-Achillis, so that there was not sufficient contractile power left in the hamstring muscle to properly elevate the heel.

Dr. A. M. Phelps said that the tendo-Achillis was undoubtedly too long, but, as he could not detect any motion in the gastrocnemius and soleus muscles, he thought it was a case of non-union of tendons.

The Chairman thought the case illustrated the danger of doing the operation on the heel-cord and on the plantar fascia at the same time. If the heel-cord be preserved until after division of the plantar fascia the operator has a fixed point from which to work upon the latter.

Dr. Gibney said that when the case relapsed an attempt was made to produce overcorrection, but it was found necessary to divide the cicatrices about the tendo-Achillis. He did not think Dr. Phelps could demonstrate that this was a case of congenital paralytic equino-varus; the position of the heel and the lengthening of the heel-cord were sufficient to explain the position of the foot without supposing the existence of any paralysis.

Dr. E. D. Fisher, present by invitation, remarked that the general appearance of the case did not favor the theory of sensory paralysis.

Dr. Parrish, present by invitation, exhibited a patient on whom he had performed anastomosis of tendon for infantile paralysis. It had occurred to him that a more useful limb might result from artificially uniting the tendon of the paralyzed muscle to that of some live neighbor in cases of infantile paralysis, and it was only a few days ago that he had learned that this was not the first case upon which the operation had been done. The operation was first performed by him on May 15, 1892, an incision being made in the space between the tendons of the extensor pollicis and the anterior tibial muscle, and these tendons then united by catgut. The foot was then placed in a position of inversion, with slight extension, and a plaster of Paris dressing applied. Before the operation there was a dropping of the arch of the foot; after the operation the child had another acute attack of infantile paralysis which affected the posterior tibial muscle. A second operation was therefore done on November 20th last, and the plaster dressing which was then applied was not removed until two days ago. In this second operation the sheath of the gastrocnemius and the tibialis posticus were cut open, the tendon scraped for a distance of about one inch, and then the two united by a catgut suture. The wound was then closed by suture, without drainage. The child is already able to walk much better than before these operations, but it is possible that another operation upon the anterior tibial will be required. The treatment now will consist in breaking up all adhesions and exercising the muscles.

Dr. Sayre said that, last spring, while looking at some of these cases of flat-foot, Dr. Parrish suggested the propriety of attaching some live muscle to the dead tendon of the tibialis posticus. The idea struck him at the time as a most excellent one, and he was glad that this first case had been distinctly benefited by this treatment. It was unfortunate that after the first operation the child should have had another attack of infantile paralysis; and this seemed to him to be largely

responsible for the imperfect result of the first operation. After the first operation the arch of the foot was well supported, but there was a marked eversion, and it was for this that the second operation was done. Two weeks ago he had himself performed the anterior operation on a girl about fourteen years of age, and he hoped to report upon her case at some future meeting. He then referred to two cases in which a similar operation had been done upon the tendons of the fingers.

Dr. A. M. Phelps then presented a case of extreme talipes calcaneus, with total loss of power of the gastrocnemius and soleus muscles, upon which he had operated in a similar manner. The operation was done on the 22d of last September, and so far as he knew at that time it had not been done before. The operation consists in shortening the heel-cord about one inch, and in uniting the tendons of the paralyzed muscle to the tendons of muscles which had not been paralyzed—the long flexors of the toes. The foot was dressed at a right angle, and although there had been quite a noticeable gain in power there had been not so marked a change in the calcaneo-valgus. It would have been better if he had placed the foot at the time of operation in a super-corrected position. He hoped now by the use of Judson's brace and by improving the condition of the muscles by electricity and massage to be able to overcome the calcaneus.

Dr. Judson said the function of this brace was to take the weight of the body from the toe and place it in the neighborhood of the tubercle of the tibia, and hence the front part of the band at the upper end of the brace should be well padded so as to make this pressure bearable.

Dr. A. M. Phelps read a paper on Tenotomy and Tendon-Grafting, with the following discussion:

Dr. R. H. Sayre said that his own experience had led him to think that where there was reflex spasm produced by "point pressure," either forcible rupture or section would be required. He did not refer to the spasm existing around diseased joints, but to cases in which there were contracted tendons wholly independent of any joint inflammation.

Regarding the boy who had been presented, he would say that his father had differed with him as to the best method of treating this boy, his father believing that tenotomy was indicated, while the speaker thought that stretching under ether would be sufficient. The parents of the boy had not agreed to the treatment proposed, and the case had accordingly passed from under their observation. He thought the boy

at present showed the same condition as the other patient presented with abnormally elongated tendo-Achillis, as shown by his inability to stand on his toes. He fully agreed with the author as to the correctness of the general principle of immediate correction after tenotomy, and also thought that in the interesting case in which Dr. Phelps had sutured the flexor muscles of the toes to the tendo-Achillis, a better result would have been obtained if the foot had been immediately placed in a position of equinus. The author seemed to imply that it would be impossible to make too long a splice in a tendon; this is not so, for there is a point beyond which the muscle can not contract. His criticisms on the "traction treatment" and its effect on the nutrition of muscle were based upon purely theoretical grounds.

Dr. W. R. Townsend said that as the author had spoken of "contracture" and "contraction" he would like to ask if any of the members could distinguish between these two conditions, for he could not, and he knew several of those present who had expressed their inability to do so. He did not think the distinction made between the two conditions of any value as a guide to tenotomy.

Dr. H. W. Berg said that these terms had a well-defined meaning, but Dr. Phelps had used them in just the opposite sense. The term "contracture" is applied to a temporary shortening of the muscle, while the term "contraction" is applied to a permanent shortening of the muscle. From this definition it follows that the muscles which should be cut are those which are *contracted*, while the *contractured* muscles demand stretching.

Dr. N. M. Shaffer remarked that the preceding speaker had given the definition of these terms as usually found in dictionaries.

Dr. Brackett, of Boston, being invited to take part in the discussion, said that he had been particularly interested in the subject of tenotomy in its relation to the treatment of club-foot in infants. In the treatment of such cases the surgeon should be guided by the individual case, not by any generally accepted rule. The earlier the deformity is corrected, the more will our efforts be aided by the process of natural growth in restoring it to a normal state. At present his plan of treatment consists in first correcting the varus by means of a brace, or by plaster bandages renewed at short intervals; then performing tenotomy, first cutting the plantar fascia; secondly, the scaphoid ligament, and thirdly, dividing the tendo-Achillis. The foot is then kept in plaster of Paris from four to six weeks. As a rule, it will be found that the foot has not only

been corrected, but will maintain its position if the precaution is taken to keep on some simple retention shoe until the child is nearly ready to walk.

Dr. S. Ketch said he would like to know on what ground the author had made the statement that mechanical treatment should be abandoned if satisfactory progress were not observed in the course of "a few weeks."

Dr. A. B. Judson thought that in the fact that our specialty was orthopedic surgery, and that our patients were growing children, was to be found sufficient justification for the continuance of mechanical treatment, not merely for "a few weeks," but for *years*. If a deformed foot is brought nearly to its normal shape, the growth of the child tends to restore the part to its normal condition, whereas if allowed to remain deformed it will grow more and more deformed.

Dr. Shaffer could not accept the views expressed by the author regarding the deleterious effect of traction on the nutrition of muscles, for his personal experience had taught him that traction when scientifically applied not only did not cause atrophy, but on the contrary resulted in an increase in the volume of the muscle. Moreover, after it has been applied, and especially in cases of infantile paralytic club-foot, it is not at all unusual to observe a pronounced increase in the temperature of the entire member, as well as an increase in motor power, even at remote points—an increase which is so noticeable as to be appreciated by the patient and made a subject of comment. Judging from the traction shoe which the author had exhibited, it was evident that he did not know much about the proper method of employing traction.

Dr. R. H. Sayre said that a not infrequent cause of failure of tendons to unite was the faulty application of dressings, by which undue pressure is made over the seat of operation, and the gap between the tendons occluded.

Dr. Phelps, in closing the discussion, said that in his use of the terms "contracted" and "contractured" he had simply quoted Barwell and Sayre. He had advised the discontinuance of purely mechanical treatment after a few weeks, because if at the end of this time he found little or no progress had been made, and the parts were rigid, he knew that by doing a tenotomy he would do the patient no harm, and would not only save much time, but would be able to remove the braces very much sooner. He did not think it was a good plan to needlessly load down growing children with steel braces for years at a time, as seen in

one of the cases presented. He did not advocate the performance of *repeated* tenotomies, but the performance of one thorough one to perfectly overcome the deformity, dressing in the super-corrected position. Traction increases the warmth of the limb only in the same way that massage increases the circulation and temperature of the parts. Where he did employ traction he preferred to use his hand to any form of traction apparatus which had been devised. He confessed his inability to distinguish between a contraction and a contracture.

Poliomyelitis Anterior Acuta Infantilis, its Etiology and Treatment—a Clinical Study of Seventy-five Cases—was the subject of a paper read by Dr. Anna M. Galbraith.

The new points raised in the etiology of this disease were the result of three years of careful observation and study of these cases. The necessity for the energetic treatment of the acute stage was emphasized. The histories of five cases seen one month after the attack illustrated that regular treatment begun at this time might often lead to a practical, if not to a complete cure of the disease, whereas, left to itself, the natural tendency was to go on to atrophy, deformity, etc.

DISCUSSION.

Dr. N. M. Shaffer said that he was familiar with the cases which formed the basis of this paper, and he could vouch for the care with which the observations had been made. Regarding the question of whether or not traumatism could be considered an etiological factor, he would say that his own studies would lead him to oppose this view; and although in the cases cited by the author the relation of cause and effect seemed clear, he would decline to adopt this view until additional evidence had been accumulated. He took very much the same position in regard to the tubercular diathesis as a predisposing cause of infantile paralysis. Her observations had led him to think that a very slight attack of acute poliomyelitis anterior could occur with complete recovery, and that such cases did occur without subsequent paralysis.

Dr. Brackett referred to a case in which there was very noticeable hyperesthesia, followed by the usual symptoms of infantile paralysis. Subsequent inquiry had elicited the fact that frequently with the fever there is marked sensitiveness, particularly at the back. He had been unable to find any mention of this hyperesthesia in the literature of the subject.

Dr. Fisher thought the history of tuberculosis in these cases was simply a coincidence, and the history of traumatism was hardly of much consequence, as such a history could be obtained in almost all children. In those cases in which the muscles respond to the faradic current within two or three weeks after the initial attack he felt sure that if they had proper care recovery would take place, but after a period of three or four months the cells are known to be so seriously affected that there is but little likelihood that the damage will be repaired, although by careful and persistent treatment certain muscles will be strengthened. It has been suggested that mechanical irritation or an electric current through a nerve may pass up the cord and irritate the nerve center in the cord, and perhaps in this way affect the nutrition of the cell. This is a pretty theory, but when the muscles have absolutely failed to respond to the faradic current, and atrophy is present, together with the reaction of degeneration in the muscle, the muscle is irrevocably lost. Continued massage and electricity will improve the condition of the neighboring muscles, but not of the particular muscle which has already failed to respond to the current. He did not see many children in the early stage of infantile paralysis, but in those which had come under his observation he had not noticed any great degree of hyperesthesia.

Dr. Shaffer said that last spring he saw three cases in which there was at first fever, then a period of marked hyperesthesia, and, thirdly, a "limp" condition, which was the stage of true paralysis. He thought the hyperesthesia was always present, especially in severe cases, to a greater or less degree. In the three cases referred to, the paralysis was more extensive and profound in those cases where the hyperesthesia was the most pronounced.

Dr. Ketch said that he had noticed in both dispensary and private practice that children having infantile paralysis presented a particularly healthy looking appearance, and he had seen nothing to lead him to suppose that these patients were tuberculous. It is reasonable to expect that many of the cases coming to the dispensary would give a history of tuberculosis, so that many more observations were necessary before this point could be considered as settled. He had had an opportunity of seeing most of the cases described in the paper, and he could testify to the marked improvement which had occurred as a result of the treatment adopted. The prevailing idea that these cases are nearly hopeless is not founded on careful clinical observation.

Dr. H. W. Berg said that an important objection to Strumpel's theory that infantile paralysis is an infectious disease is the fact that adults are never affected with poliomyelitis anterior, and the fact that two or three cases have occurred in the same family, or that in a certain town out of a population of fifteen hundred quite a number of cases have occurred, does not prove any thing. He did not think the method of treatment employed during the first month made any difference in the ultimate result, for the cells, if severely inflamed, would be permanently damaged in spite of any treatment which might be employed.

Dr. Galbraith, in closing the discussion, said she had known hyperesthesia to occur as early as the fourth day, and to last as long as two months. Its intensity and duration would appear to be in proportion to the extent of the paralysis, and it disappeared in the same order as the retrogression of the paralysis.

The traumatism must be sufficient to cause concussion of the spine in a spinal cord predisposed thereto. In two of the cases fever had occurred in a few hours, followed by paralysis on the third day.

The prognosis in the acute stage should be more guarded, since death may occur with the onset of the paralysis; and further, since many children die during the second year, at which age this disease is most frequent, and under the same circumstances, in which no autopsy is made, it must be believed that this malady is more fatal than is generally supposed.

The belief in a tubercular diathesis was based, (1) On the frequency with which pulmonary tuberculosis was found in the family history of these patients—thirty per cent. Of these, twenty-five per cent had phthisis in both the paternal and maternal families; thirty-seven per cent showed two or more members of the same family to have suffered from phthisis; thirty-three per cent had phthisis with some well-marked neuroses. (2) The profound impression made by the disease on the general health; fifty per cent subsequent to the attack showed, in addition to the profound anemia, marked emaciation with a tendency of the mucous membranes to become inflamed, enlarged glands, sore eyes, urticaria, and obstinate eczema. (3) The slight power of resistance of these patients to any intercurrent diseases, as pertussis, measles, etc.

The prognosis as to ultimate recovery or improvement in the chronic stage will depend on the extent and severity of the paralysis, the length of time which has elapsed since the onset, and the regularity with which

the treatment is carried out. At the onset of the paralysis only some of the ganglionic cells are destroyed. Others are simply disabled or threatened through congestion of the cell, great pressure, and infiltration of the tissue, as well as by lack of nourishment due to the blood stasis. Hence the necessity for treatment directed to the condition of the cord as well as the direct treatment of the muscle, stimulation of which tends to prevent its degeneration, and through the muscular contractions acts on the ganglionic cells.

THE LOUISVILLE CLINICAL SOCIETY.

Stated Meeting, January 10, 1893, Dr. J. M. Krim, Vice-President, in the chair.

Dr. J. M. Mathews: About eight months ago I was called to see a lady, thirty-two or thirty-three years of age, widow, who upon examination revealed an excessive infiltration and stricture of the rectum, extending, I should say, for six inches up the gut. At that time I knew nothing about the history of the woman. The evidence to my finger inclined me to the belief that it was syphilitic, though, taking her station into consideration, I would have doubted it if I had not seen many cases in women where their virtue was not to be questioned, so avoided giving a positive opinion as to the nature of this infiltration. I ascertained that she had had trouble with her husband and left him, and a relative told me that the man during his married life had syphilis, which is confirming evidence that my opinion was correct.

Now, as there is a pathological question which arises here, I want to state, rather reiterate, my opinion about the etiology of stricture of the rectum, that is, that the vast majority of them are produced by syphilis; and if I see a stricture of this portion of the gut that is not syphilitic, then I would strongly incline to the belief that it is cancerous, and *vice versa*. If I see a case that is suspected to be cancerous, and it turns out not to be cancer, I am on record as saying and still say that I believe it to be syphilitic in the majority of patients. I do not want to be understood as saying that I believe all strictures of the gut that are not cancerous are syphilitic. I am misquoted in that particular, and have tried to correct the matter in the Societies, etc., but there are some who will not hear it. My position then is this, and the case in question

is one that will bear me out, that if the evidence, clinical history, etc., goes to prove that a stricture of the gut is not cancerous, then it is generally syphilitic. Now this woman was or had been married, was then a widow, and I knew nothing of her clinical history, nothing of her married history or surroundings, and I believed that she was suffering from syphilitic stricture. Naturally it would be asked why I supposed so. Upon this point I wish to say that there is evidenced to the finger a peculiar condition of affairs that attends syphilis or syphilitic infiltration of the gut that does not obtain in any other character of affection that would produce by its pathological changes a stricture. I found in this woman's rectum a fibrous, non-yielding, hard stricture or infiltration. I do not know that the word hard should be used, because it so closely simulates the nodule that is sometimes felt in cancer; but I mean to say that when the finger is introduced into the rectum, as far as it is inserted, that this stricture or infiltration does not give way, does not bleed; there is no special odor or any thing of that nature in contradistinction to the cancerous infiltration which usually at least does by force give away, often bleed, often has that peculiar odor of cancer, together with the other histological evidences that are brought about or exist in such cases. This woman had that condition. The patient was put under chloroform and I broke this stricture. Upon this point I wish to say that I know my position in that one particular has been criticised. Men who are authorities in rectal surgery say that it is a dangerous procedure to break a stricture of the rectum. The majority of those who write upon the subject claim that gradual dilatation is the best method. I am so thoroughly persuaded that this position can not be maintained that I never practice gradual dilatation of any stricture of the gut, be it benign or syphilitic, and I make this distinction between benign, syphilitic, and cancerous stricture of the gut. They claim that breaking the stricture is dangerous because it produces great shock. I have only seen one single instance where great shock attended it. They claim that you may tear the gut, as my good friend Bauer, of St. Louis, says, into tatters. I claim that by breaking the stricture we accomplish more in one minute than we could by dilatation in one year. This lady went on, and it is needless to say she improved, because she had suffered before this operation with obstinate constipation; she could not have a free evacuation of any reasonable amount at all when I operated upon her. After that she had full, free evacuations for a number of months, consequently her general health improved.

After a lapse of some time I was summoned to this woman again, and I found, what I find in all cases of syphilis of the rectum, a reconstriction. I maintain that syphilitic stricture from syphilitic causes is just as incurable as cancer, and do not think that one was ever cured in the world. I do not believe that iodide of potassium can cause the absorption of syphilitic stricture. I proposed to the family of this woman to do a different operation. I submitted to the family the possible necessity of a colotomy, assuring them that she could never get any better, at least could not recover by breaking the stricture. I saw in the case, if it be syphilis, great advantage in a colotomy; they told me to submit it to the patient, she was a very sensible business woman. I submitted the proposition, and she gladly accepted it and appointed a day for me to do the operation upon her. In the interim, on re-examination, I found in addition to this close constriction a deposition of material extending likely into the sigmoid flexure, and at that sitting I also examined her uterus, and to my surprise I found the womb in such condition as to persuade me that it was a cancer. Now here was a question which arose in my mind, and it is the main question that I wish to submit to the Society: Was I wrong in my first conclusion? If this woman has a cancer of the uterus, is it not simply an extension from the rectum; or, as I am more inclined to believe—and it is a pathological question that I have never been able to settle in my own mind—is it not true that she may suffer from this syphilitic deposit in the rectum, and that it has undergone a cancerous degeneration? I was not willing, therefore, to rest the case upon my own opinion, and asked her to see a gynecologist. Dr. L. S. McMurtry kindly examined her, and informed me that there was excessive cancerous disease of the uterus, and I said to him at the time, "If that be true I do not believe colotomy is advisable." I will not occupy your time giving my reasons why colotomy was not justifiable, or the advantages of performing a colotomy in that condition. These conditions have so often been discussed that I will not speak of them here. Therefore I was compelled to say to this good woman that I did not believe even the *dernier ressort* of colotomy would benefit her at all. She is a good Christian woman, accepted the burden, and is preparing to die, as of course she can not live very long.

This is the condition of the patient to-day, and the main point I wish to raise, if it is discussed at all, is, do these syphilitic deposits, or does syphilis degenerate into cancer or malignancy? If answered in

the affirmative, then I believe that I was correct in the beginning. I am persuaded that it was syphilis of the rectum in the beginning. She gave a syphilitic history after I ascertained from other quarters that her husband had syphilis. The evidence is clear and positive that it was a case of syphilitic stricture of the gut, and yet I find cancer of the womb. It is a strange coincidence that the woman is suffering from cancer of the uterus, and at the same time syphilitic deposit of the rectum.

Dr. J. G. Cecil: It is an exceedingly interesting case, and I can hardly let it go by without asking a question at least. I would like to know of the narrator what was the probable age of the cancer in the uterus at the time it was discovered, and how would that length of time, that probable age of it, compare with the first examination or first evidence of stricture of the gut. To my mind I do not see any special reason why this woman could not have had a syphilitic stricture of the rectum and at the same time cancer of the womb; so that Dr. Mathews might have been entirely correct in his original diagnosis, and equally correct in the conclusion which he came to, that there is nothing, perhaps, in a surgical way that gives any hope. The slight experience I have had with syphilitic stricture of the rectum bears out what Dr. Mathews has said, as far as gradual dilatation of the gut is concerned where syphilitic deposits occur, that it does not amount to any thing; at least I have never succeeded in relieving the patient to any great extent. It is a constant source of trouble both to the physician and the patient. Dilatation in the very crude way in which I have been able to perform it with the ordinary instruments has been a very unsatisfactory one, so that if rapid dilatation can be done, as Dr. Mathews says, without danger, it seems to me that it would be infinitely preferable, as by rapid dilatation under anesthesia we can accomplish at one sitting results which would require perhaps six months or a year to obtain by gradual dilatation.

In regard to syphilitic stricture of the rectum, I am not very familiar with the literature of the subject, but it seems to me that some of them situated low might be resected, especially in the female, as you would have the vagina through which to work, if necessary, or at least to help in getting at the case. I would like to ask Dr. Mathews if this would not be the proper procedure.

Dr. L. S. McMurtry: I am convinced that Dr. Mathews' views upon the case reported are correct. I believe the stricture is syphilitic, and

that the development of carcinoma of the uterus was subsequent to the deposit about the rectum. Cancer of the uterus varies as to the degree of malignancy and rapidity of progress. In the case under consideration the process of cell proliferation and infiltration has been rapid in its progress. I am sure that in this case the syphilitic ulceration antedates the cancerous development in the cervix uteri.

Dr. Mathews: While Dr. McMurtry was speaking I was reminded of the fact that upon several occasions lately this patient said to me, "Doctor, I am losing a great deal of blood," describing it as gushing away from her. For the first time or two I of course thought it was dependent upon the rectal trouble, and thought it strange that she should lose this amount of blood from a syphilitic deposit; but when she came to explain that the hemorrhage was from the uterus I was led to make an examination of it. Now, if you will notice, here is just as extensive or perhaps more extensive infiltration or pathological change in the rectum without the least loss of blood, the hemorrhage being only from the cervix uteri. This is the main point I make in drawing the distinction between syphilitic deposit and malignant deposit. Here she has had for several years a syphilitic deposit in the rectum with no discharge of blood, and within a little time after the development of the trouble in the uterus she loses a great deal of blood, which is a point I think in making my diagnosis stand.

In regard to Dr. Cecil's remarks: When this patient first came under my observation I examined her uterus as best I could with my finger, and there was no evidence of any trouble, nor did she complain of any until she was losing blood, and only called attention to that within the last few months. Therefore the rectal trouble must have antedated the cancerous condition of the uterus a number of months, if not several years, from the fact that when I first made an examination of the rectum the constriction was so small that I could not pass my little finger through it. The treatment of strictures of the gut by excision has been in vogue for a number of years, and is more popular now than it has ever been, because some American authorities especially are in the habit of resecting or exsecting strictures of the gut where they are within reach, and where healthy mucous membrane can be secured above and pulled down and stitched below to the true skin. Of course this can only be done in exceptional cases, where the stricture occurs sufficiently low to enable you to get at it. If it is five or six inches up the gut, it is impossible to reach it to resect. Another thing that

should be taken into consideration in this connection, and that is in resecting we interfere with the sphincter muscle, which is not done in dilatation for stricture. I believe dilatation preferable, because we not infrequently see incontinence of the feces following resection for stricture.

T. C. EVANS, M. D., *Secretary.*

LOUISVILLE.

Reviews and Bibliography.

A Treatise on Nervous and Mental Diseases, for Students and Practitioners of Medicine. By LANDON CARTER GRAY, M. D., Professor of Nervous and Mental Diseases in the New York Polyclinic, etc. With one hundred and sixty illustrations. 687 pp. Philadelphia: Lea Brothers & Co. 1893.

It is said to have been said by Webster, and no doubt has been said time and again from the days of the pyramids, that there is always room at the top. However this may be, there can be no gainsaying that there is always room in the field of medical literature for such works as this treatise of Dr. Gray.

In the first place, it is by a man who is thoroughly capable and thoroughly honest. The reader does not fear in studying these pages that the author will color or strain facts to suit preconceived views or even to be sensational. He knows that he is traveling with one who seeks only truth, and who has exceptional capacity for knowing it when he finds it. In the second place, his facilities for study are second to those of very few men in any country. We could not, under the conditions, reasonably expect any thing but a good book, and the result confirms the reasonableness of our expectations.

The work is brought down to the very latest date, and sets forth whatever of value has been accomplished by the many trained neurologists who are now sedulously and zealously employed throughout the world in the investigation of nervous diseases, special and full attention being given to newly discovered types of disease.

Dr. Gray appears also to have kept in mind the fact that he will have many readers who from his book and their own observation must make their acquaintanceship with nervous diseases, for he has apparently made special effort to be plain and simple in his style of describing diseases. As to treatment, the author takes the median path, and the one which almost by a law of nature carries with it the presumption of being the correct one. Coming to special features regarding debated points, the author is specially and we think justly severe on those who would attribute nearly every nervous disease to reflexes, usually to the particular organ or organs to which

the physician happens to bear the relation of specialist. As to their frequency he declares that "it may be positively stated that they are extremely rare, and I have no doubt whatever that every neurologist has an experience identical with my own, namely, that many and many a case of so-called nervous disorder will be resolved into a familiar nervous disease which has not been recognized."

As regards reflex disorders in the female of pelvic origin, he employs this plain language: "Gynecological surgery is so fascinating, the temptation to report a series of one hundred cases is so great, and women are such easy victims, that an enormous affirmative literature has grown up upon this subject, to be met by an equally enormous negative literature on the part of neurologists, as an outcome of which the brain and spinal cord have been almost transferred from the skull and the vertebral canal to the pelvis, and anatomical teachings have been well nigh revolutionized in the mind of the general practitioner. . . . There is not a case on record in which epilepsy has been cured by any operation on the female pelvic organs." "Diseases of the male urethra have been supposed to play as large a part in the causation of reflex disorders as the pelvic lesions of the female. I believe, however, that the one view is as much due to defective observation as the other." "Statistics are perfectly valueless upon this question, because every thing depends upon the experience and the knowledge of the person making the diagnosis, and it is a significant fact that none of the well-known neurologists of the world have reported cases of reflex nervous disorders within the last ten or fifteen years."

The author goes perhaps as far as Erichsen in his estimate of the frequency of spinal concussion or railway spine from railway accidents.

As to style, one can not speak so unqualifiedly favorably as he may in regard to doctrines. Sentences are sometimes too much involved, some notable examples being found on page 367, one of them being enough, in our opinion, to mar several pages. Altogether, however, we have here a superb work, second to perhaps only one in the language, and in fullness of scope second to none.

D. T. S.

International Clinics: A Quarterly of Clinical Lectures on Medicine, Neurology, Pediatrics, Surgery, Gynecology, Ophthalmology, Laryngology, Otology, and Dermatology. By Professors and Lecturers in the leading Medical Colleges of the United States, Great Britain, and Canada. Edited by JOHN M. KEATING, M. D., Colorado Springs, Col., JUDSON DALAND, M. D., Philadelphia, I. MITCHELL BRUCE, M. D., F. R. C. P., London, Eng., DAVID W. FINLAY, M. D., F. R. C. P., Aberdeen, Scotland. Volume 1, Second Series, 1892, 363 pp.; Volume 2, 373 pp.; Volume 3, 398 pp. Philadelphia: J. B. Lippincott Company. 1892.

These three volumes of the second series of *International Clinics* show a distinct improvement on the series of 1891. All the contributors appear to have got in their best work. The literature here presented differs from what is commonly met in medical journals. In these it is for the most part what is new and rare that is aimed to be presented, and there is a seeming

forgetfulness that to very many readers there are vast numbers of everyday matters that are not new, but which greatly need to be learned. These international clinics supply food for the minds of medical students, presented in such a way as to be made most available. The medical world has been well searched for contributors, and the editors are to be highly commended for the excellence of their selections.

D. T. S.

Abstracts and Selections.

OBSTETRICS.—The termination of a tedious labor by forceps is usually such a relief both to patient and attendant that it is not a matter of wonder if sometimes sufficient attention is not given to possible injury which may be inflicted on mother and child. Much has been and is still being written on this subject. No more excellent summary of the whole question is to be found than that in the American System of Obstetrics. Dr. J. G. Swayne, recently calling attention to some of these dangers, refers to the often overlooked risk of compressing the cord in cases where it is coiled around the neck, and advises the operator to be careful not to pass either blade of the forceps unnecessarily far.

A new interest for English readers is given to obstetric traumatism by Dr. George H. Rohé, of Baltimore, who, in a paper at the June meeting of the American Medical Association, stated his belief that puerperal mania often takes its origin from some lesion of the genital tract. He gave the details of some cases, from a consideration of which he felt justified in believing (1) that in at least the majority of cases puerperal insanity is an infective psychosis, (2) that careful observation will show that few cases of puerperal insanity occur without a preceding or coincident puerperal infection. For this belief he gave the following reasons:

1. Puerperal insanity occurs in the great majority of cases within the first ten days after delivery (about one half in the first five days) the same period during which puerperal infection usually occurs.

2. It is usually accompanied by elevation of temperature and other evidences of febrile disturbance.

3. The clinical form in which puerperal insanity manifests itself is, in the majority of cases, that of acute delusions or confusional mania. Depressive states are rare, except as secondary lesions. In other words, the most frequent condition is one most closely resembling febrile delirium.

4. The death-rate is much higher than in simple mania. Death occurs from exhaustion, usually with high temperature and rapid pulse.

5. *Post-mortem* examinations, though apparently infrequent in these cases, have shown grave involvement of the pelvic viscera.

6. Examinations of the pelvic organs during life show lacerations of the perineum and cervix uteri (facile channels of infection in the puerperal woman). As secondary conditions are found intra-pelvic (peritoneal) inflammation, and consequent abnormal locations, fixations, and congestions of the uterus, tubes, and ovaries.

7. The results of operations seem to show that removal of local sources of irritation increases the chances of recovery from the mental disease.

A sufficient number of cases showing cause and effect has not yet been recorded, but Dr. Rohé's suggestions are valuable in directing attention to any possible factor which may give rise to this distressing affection, and they afford a reason for additional care in endeavoring to avoid the least parturient lesion of the uterus or vagina.

Independently confirmatory of Dr. Rohé's theories come the observations of Prof. Olshausen, who has called attention to the relation of psychoses to grave infectious disease of the puerperium. He considers that cases of puerperal pyemia, with ulcerative endocarditis, are those that are usually followed by mental disease.

Traumatisms of the cervix deserve more consideration than they often receive. Fraisse holds that every delivery at term in a primipara is accompanied by a laceration of the cervix. He arranges such injuries into four classes. Those of the first degree undergo immediate repair. In the second class the laceration extends beyond the margins of the os, but stops at the vaginal insertion. In the third degree, which is of a very grave character, the wound may extend as far as the peritoneum. The fourth form is in reality a rupture of the uterus. Fraisse dwells with some detail upon the injuries of the third degree, which present the same symptoms and require the same treatment, whether their origin be art or nature. The first symptom is hemorrhage, which is differentiated from that caused by uterine inertia, by noting that the contractions and retraction of the uterus occur normally. Fraisse says that if the uterus is firmly contracted, and if there are no external lesions, any abundant hemorrhage may be assumed to have its origin in a laceration of the cervix, which extends beyond the insertion of the vagina. In such a wound there are obvious dangers of an immediate nature. The hemorrhage may usually be stopped by pressure. Infection through the wound must be prevented. The remote results are familiar to gynecologists, and manifest themselves by pain, inflammatory troubles, sterility, and abortion.

Without doubt the child often shares with its mother the disadvantage of receiving injuries which are either not observed or not manifested at the time. Dr. L. L. Gray, in calling attention to some types of paralysis in young children, adds to the testimony already existing concerning the production of these by injuries due to difficult delivery or the use of instruments.

Quite a formidable list of ocular injuries received in forceps delivery is given by a writer in the *Medical News* of April 16, 1892. All the evidence.

excessive but much disregarded, should make the obstetrician ever on his most acute guard to minimize the dangers which may arise to mother or child by the use of the forceps.

A curious note on unavoidable brain injuries is supplied by Dr. F. W. Goodall, who attributes our right-handedness to a condition of left-handed weakness produced, through the frequency of the child presenting in the first or fourth position, by the right side of the head being subjected to a greater degree of mechanical pressure and violence than is the left side.

Writing on *The Pelvic Symphyses in Pregnancy and Parturition*, Dr. W. J. Conklin supports the conclusions of Luschka that these symphyses are true joints provided with synovial membranes, and capable of limited motion. Under the stimulus of pregnancy the softer structures of the symphyses undergo a general relaxation, which necessarily leads to a slight separation of the articulating bones. Dr. Conklin does not discuss the question of the mobility of the sacro-vertebral and sacro-coccygeal joints, as he believes it is admitted by all obstetricians. He adduces a goodly array of evidence in support of the view that there is during labor a considerable separation of the sacro-iliac symphysis and of the pelvic joints. Admitting that separation of the pelvic joints does take place to a greater or less extent in many (if not all) women at times, its value as an obstetrical factor depends wholly upon the extent of the separation. It becomes difficult to decide whether in some of the recorded cases the relaxation was normal or pathological. Probably the cases in which the separation was considerably over an inch were of the latter class. Dr. Conklin gives details of some of his own cases, in which the relaxation exceeded physiological bounds, and caused pain and disability, partial or total, of the lower extremities. He infers that many labors which, contrary to expectation based upon former experience, have proved to be short and easy, have been so on account of considerable relaxation of the symphyses during pregnancy, by which the pelvic circumference has been notably increased.

In the English 1890 edition of Winckel's *Midwifery* a fervent wish is expressed that the operation of symphysiotomy should be forever entombed. Recent experience shows that this wish is now farther than ever from being attained. The operation of separating the pubic bones at their junction with one another, usually called symphysiotomy, was introduced before the Royal Academy of Surgery of Paris in 1768 by Sigault, who hoped that it would take the place of cesarian section. After some adverse criticism the operation became for a time a popular one. It then became discountenanced, and till its partial revival in Italy, about twenty-five years ago, had passed out of obstetric practice. It seems likely, however, that the operation will become a recognized one, and it promises under antiseptic precautions to be a remarkable success. The credit of this is mainly due to Prof. Morisani, of Naples. Dr. Robert P. Harris gives a full review of the history of the operation and its mode of performance. From January 1 to October 8, 1892, there were 52 operations, with 1 death.

In the cases of recovery the unions were good, and there was no resulting lameness. Seven children were lost; only one was born dead. Three were born in an asphyxiated condition, and the rest died during the first three days. If the child did not survive beyond the first three days it was counted as lost. Out of 52 children, 45 lived; 51 were born alive.

A. Pinard considers that with antisepsis the operation is not only devoid of danger, but is beneficial. He says that the pubic bones can be separated to the extent of six centimeters, and that the operation itself is not difficult. Pinard is of opinion that in many cases this operation should take the place of embryotomy and of cesarian section, that the lives of many women and children may be preserved by it, and the practitioner be saved the cruel necessity of crushing the skulls of living infants.

Dr. W. T. Lusk, commenting on Dr. Harris' paper, said that it gave him great pleasure to find that symphysiotomy had been of recent years so far perfected that it gave a lower maternal death rate than craniotomy.

Dr. B. C. Hirst gives a summary of the statistics of the operation, which down to 1858 had a maternal mortality of 33 per cent. From 1866, when it was again practiced, till 1886 the mortality was 24 per cent. Dr. Hirst says the first operation in America was performed by Dr. Charles Jewett, of Brooklyn, on September 30th of this year. He considers the modern revival of the operation to be the most important advance in obstetric surgery since the general adoption of abdominal section in early extra-uterine pregnancy. Dr. Hirst gives the clinical records of some typical cases, including one in which he operated at the University Maternity of Philadelphia. The choice was between cesarian section, craniotomy, or symphysiotomy. Mother and child did well. Dr. Hirst gives details of the operation, which he considered should be performed with Galbiati's knife. A fuller account of the mode of operation is given by Dr. Harris. Dr. Anna E. Broomall performed a similar operation at the Women's Hospital, Philadelphia, on October 7th. On October 14th mother and child were both doing well. In the discussion that followed the reports of the cases of Dr. Hirst and Dr. Anna Broomall it was pointed out that the introduction of antiseptics had revolutionized the operation. Its performance has now received the additional sanction of Charpentier and Porak, of Paris, Leopold, of Dresden, and Freund, of Strassburg, all of whom have had successful cases.

Porak's first case is specially instructive. After making all justifiable attempts with the forceps he failed to deliver the disproportionately large child. He did not think that the case was one for cesarian section. He opened the symphysis, put on the forceps a second time and accomplished the delivery without trouble. The woman recovered, and the child lived.

On November 22d Dr. W. J. Smyly performed the operation at the Rotunda Hospital, Dublin. This is said to be the first symphysiotomy in the United Kingdom since 1782. Nine days after the operation mother and child were doing well.

In the light of these recent successes, and of the fact that symphysiot-

omy has been chosen as a subject for discussion at the International Congress, it is of interest to note the views of the older obstetricians on the question. William Hunter, arguing from experiments on the cadaver, not realizing that after death the elasticity of the ligaments soon becomes lost, stated that the symphysis pubis could not be separated to the extent of an inch and a half without lacerating the sacro-iliac ligaments. Ryan cited "unanswerable objections to this highly dangerous and unwarrantable operation." Ramsbotham says: "The operation is not justifiable in cases of the more deplorable distortions of the pelvis, nor in the smaller degrees of diminution, because in them craniotomy can be performed." Matthews Duncan believed that there was a future for the operation, and entered a protest against the unfounded calumnies which had been directed against it by British authors, who "have raised difficulties about it which are sufficient to deter a superficial inquirer from its consideration." He quotes the words of Denman, who, although he spoke cautiously about the operation, did not "mean to insinuate a wish or advance an argument in favor of this operation in the cases for which it was originally proposed." So quickly has the change of opinion come about in reference to this operation that no longer ago than 1889 Dr. Robert P. Harris, now one of its most enthusiastic advocates, said that "symphysiotomy can not take the place of the cesarian section and its modifications, except to a very limited extent. It has a range of only a fraction over half an inch.—*L. M. Griffiths, Bristol Medico-Chirurgical Journal.*

"CONGLUTINATIO LABIORUM."—Ross (*Centralbl. f. Gynäk.*, No. 15, 1892), in reference to a case of "conglutinatio," or adhesion of the labia in children through inflammatory changes, published by Säger last year, describes a second in his own practice. The child was about a year old. The urine escaped in a stream directed forward. The adhesion of the labia was unusually firm, so that it could not be broken down by simple traction. A director was passed carefully through the adhesion, and the labia divided by short snips with dressing scissors. There was some bleeding when the posterior part of the adhesion was cut through, but the hemorrhage was thoroughly stopped by pressure. Ross also notes that he was once sent for by a colleague to pass a catheter for a patient who had suffered for twelve hours from retention of urine. Pregnancy had been diagnosed. Ross saw at once that a large hematocolpos existed. On palpation the distended bladder could be felt above the pubes, and behind it was the hematocolpos, which reached to the umbilicus. The uterus, swollen and movable, could be distinguished on the top of the swelling. The obstructed vagina bulged at the labia. As soon as the prominence was pushed back the catheter could easily be passed. The abnormality was successfully treated by operation. An elder sister of the same patient had also suffered from hematocolpos, which likewise caused retention of urine.—*British Medical Journal.*

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"NEC TENUI PENNÂ."

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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HYPNOTISM AND THE HYPNOTIC MEDIUM.

In commenting upon the doings of Mesmer, Thomas Carlyle, in his French Revolution, says "Man is what we call a Miraculous creature with Miraculous power over men; and, on the whole, with such a life in him, and such a World round him, as victorious Analysis, with her Physiologies, Nervous-systems, Psychic and Metaphysic, will never completely *name*, to say nothing of explaining. Wherein, also, the quack shall in all ages come in for his share."

It is clear that the philosophical historian had no adequate conception of that wonder, hypnotism, which, under the hand of Mesmer, a hundred years ago, held the hereditary and scientific aristocracy of France entranced in its charmed circle till the thunders of the Revolution broke the spell. Mesmer was a quack, but like all other successful quacks depended on something more than pretense and presumption, on his own part, and foolish credulity on the part of his dupes as media wherewith he filled his coffers with gold. In truth he had revived one of the psychological mysteries of pre-classic, classic, and medieval times, and set the neuro-physiologist a puzzle which the genius of science is still laboring to explain.

Ancient and medieval annals give account of hundreds of instances of auto-hypnotism, where in trance, in the prophetic mood, and in ecstasy, the hypnotic state had been exhibited; but it was not till 1778,

when Mesmer began his career in Paris, that the scientific world had any conception of the wonderful influence of mind upon mind, as since exhibited in cases without number by hypnotizers upon susceptible subjects. Interest in the subject during the last forty years has become almost a scientific craze, and its bibliography alone, as compiled by Dessoir, now fills ninety pages quarto of closely printed matter.

Auto-hypnotism can never claim the interest as a scientific study that belongs to hypnotism induced in one person under the influence of another, since the normal nerve integrity of the auto-hypnotic may always be reasonably held in question. The person who becomes hypnotic under the hand of the hypnotizer may be and often is a person of unsteady nervous balance; but it can not be denied that many persons sound in mind and body are good subjects for hypnotism.

It is well known that in France the subject of hypnotism has received epoch-making study in the two great schools, of Paris under Charcot, and of Nancy under Bernheim. Charcot, too much influenced, perhaps, by the hyper-sensitive mob of hysterics, hystero-epileptics, cataleptics, etc., under his care at the Salpêtrière, holds the hypnotic state to be pathological, and attaches little or no importance to the influence of the operator upon the percipient. By so doing he discounts much of the subtle influence of mind upon mind, and would feign blot out perhaps the most astonishingly interesting chapter in the annals of psychology.

Bernheim, with subjects more normal in nervous organization, holds the hypnotic state to be physiological, and makes the chapter luminous with psychological truth. But Charcot and Bernheim both make suggestion the medium of hypnotic influence, and leave untouched the most marvelous incidents of the hypnotic state. That suggestion is not competent to account for a very large part of the phenomena of hypnotism can not to-day be denied, since in hundreds of instances it has been and may be shown that the mind of the operator may influence the sensorium of the percipient where suggestion through the avenues of any known special senses is out of the question. And because of these facts another school of hypnotism sprung up, whose principal workers are Prof. Henry Sedgwick and his eminent co-laborers in the English Society for Physical Research.

Before the International Congress of Experimental Psychology, assembled in Paris in the summer of 1889, reports of experiments and tests were read by the late Mr. Edmund Gurney and others of the Eng-

lish Psychic Society, which conclusively prove thought and sensation transference from hypnotizer to subject, be the medium what it may.

We quote the account of one or two of these experiments from an able paper "Concerning a Psychic Medium in Hypnotism," by R. Osgood Mason, A. M., M. D., in the *Arena* of April, 1891. Mr. Gurney and Dr. A. T. Myers were the observers: "Subject, Mr. C., operator, Mr. S. There was no contact between them. C. was in the hypnotic state, and was not informed beforehand of the nature of the experiment. The operator stood behind the subject, and Mr. Gurney standing behind the operator handed him the different substances, and he placed them in his mouth. First salt was placed in the operator's mouth, the subject, C., instantly and loudly exclaimed, 'What's that salt stuff?' Sugar was then given. C. replies, 'Sweeter; not so bad as before.' Citric acid given. C. replies, 'Bitter; something worse; reminds me a little of cayenne—sweety.' A raspberry drop. Reply, 'A sweetish taste, like sugar.' Salt given again. Reply, 'I told you I like sweet things, not salt; such a mixture!' Powdered ginger. Reply, 'Hot—dries up your mouth—reminds me of mustard.' Sugar was given again. Reply, 'A little better—a sweetish taste.'" The author quotes from Dr. Hammond an experiment which he had often exhibited in the presence of abundant witnesses. Hypnotizing a subject, Dr. H. would leave him in a closed room with an observer, while the doctor went into another room with another observer, a hundred feet distant. "This one, for instance, scratches my hand with a pin, and instantly the hypnotized man rubs his corresponding hand, and says, 'Don't scratch my hand;' or my hair is pulled, and immediately he puts his hand to his head, and says, 'Don't pull my hair;' and so on, feeling every sensation that I experience."

In view of these and many more quoted phenomena to the point, Mr. Mason argues ably the existence of a psychic medium, like the hypothetical luminiferous ether of the physicists, through which the mind of one man may influence or operate upon the mind of another. Whatever the means of communication may be the facts are overwhelming, and hypnotism, after a hundred years of tossing to and fro among quacks, theorists, jugglers, and scientists, stands to-day upon an unshakable scientific basis, a living miracle among the phenomena of mind.

Notes and Queries.

TWO CASES OF LOCOMOTOR ATAXY WITH CHARCOT'S JOINT DISEASE.—

1. J. B., aged fifty-three, was admitted to the hospital on August 11, 1892, with the following history: He had passed most of his life in the merchant service, and dates the commencement of his troubles from an attack of gastro-enteritis three years ago. Following this he had a girdle sensation, and eighteen months ago his left knee began to swell, and has painlessly increased in size since. There is a well-marked history of syphilis.

On admission the patient was found to be far from intelligent, and stated that he had come to have his knee operated upon. The whole knee, when the patient sits, feels tense, and all the tissues are enlarged, with some increase of arthritic fluid. When the patient attempts to walk, which he is in the habit of doing with a crutch, there is a remarkable luxation of the femur and tibia. The line of the femur is altered, and the external condyle apparently wholly or in part destroyed, allowing the head of the tibia to be displaced inward, as in a case of marked genu valgum. There is absolutely no pain, and the right knee is unaffected.

The patient has many of the well-known symptoms of tabes dorsalis—ataxia and inco-ordination, speech and intelligence altered, knee-jerks completely gone, girdle sensation, some anesthesia of lower limbs, bladder crises, shown by occasional attacks of retention and formerly involuntary micturition.

The pupils are not very characteristic, except that they are both small. They are unequal, and fail to react to either accommodation or light. The superficial reflexes are considerably increased.

2. John B., aged forty-eight, curiously enough came to the hospital on the same day as the previous case, and was admitted on August 13, 1892.

The following was the history: He was in the army twenty-one years, and left it ten years ago. Twenty-six years ago he had a spear wound in the chest, and four years ago an attack of right facial paralysis, due, he thinks, to cold. There is no definite history of syphilis. Eighteen months ago he first noticed symptoms of the present disease. He had difficulty in walking, and weakness in the left leg, with well-marked lightning pains. Some four or five months before admission, owing to his inco-ordinate walk, he fell while trying to get into an omnibus, and from that time he noticed that his right knee was much worse and began to swell. While in London he was suspended, and since then has lost his lightning pains.

On admission he had many symptoms comparable with the previous case. His intelligence was low, and his ataxia was most marked. The enlargement of the right knee was very apparent, and there was also slight

enlargement of the left knee. The swelling was painless, and resembled the enlargement already described, but the luxation was different. There appears to be more softening than destruction; and while the line of the femur is altered, the tibia is displaced backward, as in a case of hyper-extension.

This case presents more markedly than the previous one the symptoms of tabes dorsalis, nearly all the recognized features being present. His inco-ordination and ataxia are most marked. He has altered speech and intelligence. His pupils are pin-point, and give the Argyll-Robertson reaction. The knee-jerks are quite absent, and he has some anesthesia of the lower limbs, with delayed sensation. He has crises of various kinds, notably intestinal and vesical, and in addition he still has some facial paralysis on the right side.

Remarks: During the last twelve years no such typical examples of tabetic arthropathy as the two cases here recorded have come under our observation at the Devon and Exeter Hospital. It is known that cases of this kind are occasionally mistaken for disease of a joint requiring amputation or excision, and it is certainly conceivable that such might be the case where the nervous symptoms are slight while the joint disease is very serious. Again, as M. Charcot long ago pointed out, the arthropathy is an early symptom in locomotor ataxy, and he very properly insists that the absence of pain and inflammation is a most important point in the diagnosis of all diseases of the joint caused by locomotor ataxy. Two cases very similar to those now recorded are reported by Dr. James Murphy, of Sunderland. As regards the bearing of syphilis as a possible cause of the joint disease, it will be observed that in the first case there is a well-marked history of syphilis, while in the second one it is doubtful, though the fact that the man had facial paralysis is possibly suggestive of an old syphilitic infection. Virchow opposes the view that the joint disease occasionally found in tabetic subjects is a special arthropathy different from all other joint affections. He has no doubt at all that the usual causes of joint affection (mechanical and thermal causes) are sufficient to explain the disease. In his opinion a large proportion of cases assumed to be tabetic were plainly syphilitic, and there is no doubt that arthritis deformans is the disease to be kept the most in mind. In the description of syphilitic affections of the joints given by Berkeley Hill and Arthur Cooper in the second edition of their work on Syphilis, the extensive and painless dislocations so characteristic of the affection in locomotor ataxy are not mentioned at all as occurring even in tertiary affections, and the joint is described as fixed, contracted, or much limited in its movements. The temperature too is often raised, as pointed out by Dr. Duffin.—*Bristol Medico-Chirurgical Journal*.

THE INTERNATIONAL CONGRESS OF CHARITIES, CORRECTION, AND PHILANTHROPY.—June 12-18, 1893. Section Three on the Hospital Care of the Sick, the Training of Nurses, Dispensary Work, and First Aid to

the Injured. One of the series of International Congresses to be held in Chicago in 1893 is to be devoted to the subjects of Charities, Correction, and Philanthropy, and the Third Section of this is to consider all matters relating to the Hospital Care of the Sick, The Training of Nurses, Dispensary Work, and First Aid to the Injured. The Committee of Organization of the Congress has appointed Dr. John S. Billings, Surgeon U. S. Army, as Chairman of this Section, and Dr. Henry M. Hurd, Superintendent of the Johns Hopkins Hospital in Baltimore, as its Secretary, and has authorized and requested them to complete its organization, to extend invitations, and to prepare a programme for its work. Miss Isabel A. Hampton, Superintendent of the Training School for Nurses of the Johns Hopkins Hospital, has been appointed Chairman of that part of the work of the Section which relates to the training of nurses.

This Section will hold five sectional meetings of about two hours each, commencing June 12, 1893, and will also have charge of one of the general sessions of the Congress, viz., that held on the morning of June 14th.

It is desired that this shall be a truly international gathering for conference on the subjects allotted to this Section, and all who are interested in Hospitals, in Training of Nurses, in Dispensaries, or in First Aid to the Injured are cordially invited to be present to contribute papers and to take part in the discussions.

The papers and proceedings will probably be printed as a separate volume, and it is hoped that this will represent the best methods and the best work in each of these departments in all parts of the world.

The following are suggested as subjects for special consideration in papers to be prepared :

1. Hospital Organization, Governing Bodies, Relations of the Medical Staff and of Nurses' Training Schools.
2. Hospital Finances, Means of Support, Mode of Keeping Accounts, Cost.
3. Plan and construction of recently built General Hospitals, embodying the latest improvements.
4. Relations of Hospitals to increase of Knowledge, to Medical Education, and to the Medical Profession. Hospital Records, Statistics, and Reports.
5. Pay Patients in Hospitals.
6. Isolating Wards and Hospitals for Contagious Diseases.
7. Hospital Diets, Dietaries, Kitchens, etc.
8. Hospital Amphitheaters and Operating Rooms.
9. Hospital Laundries and Disinfecting Establishments.
10. Army and Navy Hospitals, Emergency Hospitals in Time of Epidemics, Temporary and Movable Hospitals.
11. Small and Special Hospitals, Cottage Hospitals, School Hospitals, Private Hospitals, Sanitariums, etc. Convalescent Hospitals, and what to do with Incurables.

12. History and present condition of Hospitals in the large cities.
13. Training Schools for Nurses. (See special circular.)
14. Dispensaries, Relations to the Public and to the Medical Profession. Dispensary Records.
15. First Aid to the Injured. Associations for best means of popular instruction in and its place in General Education.

Persons desiring to present papers, or to share in the discussions of this Section, are requested to communicate with the Secretary at once. The period of time allotted for the preparation of the programme is necessarily brief, and it is essential that all who are willing to assist in this work should act promptly.

John S. Billings, M.D., Chairman; Henry M. Hurd, M.D., Secretary. Address all communications to Dr. Henry M. Hurd, The Johns Hopkins Hospital, Baltimore, Md.

INTUSSUSCEPTION.—Baur (*Berlin Klin. Woch.*, Nos. 33 to 35, 1892) gives a detailed account of nine cases of intussusception treated in Leibermeister's clinic at Tübingen between 1871 and 1891. He says that in some cases intussusception may exist even for months without producing adhesions between the serous coat of the invaginated part and that of the sheath. The commencement of the disease is most commonly acute, and is sometimes preceded by gastro-intestinal affections. In these cases partial or complete obstruction of the intestinal lumen takes place, accompanied by a stasis of the contents of the bowel above the point of obstruction and symptoms of strangulation. In those cases in which the abdominal walls are not too thick, and meteorism is not a marked feature, by palpation it is possible to feel either a definite tumor or a localized area of deep resistance. The tumor is sausage-shaped, somewhat hard in consistency, and is most easily palpable during the periods when the patient is suffering from severe attacks of colic. The tumor often changes its position in the abdominal cavity as well as the direction of its long axis. In a few cases, when the intussusception occurs in the lower part of the intestine, the tumor can be felt with the finger introduced into the rectum. Spontaneous cure may take place by expulsion of the invaginated part *per rectum*, and in some cases reduction of the intussuscepted mass is followed by recovery. As regards treatment, if palliative measures are to be adopted the patient must be kept in bed and fed upon a diet which produces very little solid residue. Opium or morphine must be given either by the mouth or subcutaneously for the alleviation of pain and the attacks of colic. This is especially indicated when the attacks of vomiting are violent. In some cases copious lukewarm water enemata, administered through a long India-rubber tube passed some distance up the intestinal canal, were found to be very efficacious. In those cases in which active surgical interference is requisite the author advises that a laparotomy should be done, followed by a manual reduction of the intussuscepted part if no adhesions of the adjacent serous

surfaces have formed. If, however, reduction in this way is prevented by the presence of adhesions, resection of the affected part must be performed and the two ends of the intestine brought together with sutures. Out of the 9 cases reported, 7 terminated fatally and 2 recovered. According to Leichenstein, in those cases in which expulsion of the invaginated part takes place the prognosis is somewhat better than in those in which this does not take place. The mortality of the former is 41 per cent, and in the latter 85 per cent.—*British Medical Journal*.

A HEAVY BRIDAL COUPLE.—There was recently married at one of the dime museums a couple whose united weight is said to be 1,179 pounds, the bridegroom weighing 607 pounds, and the fair bride 572 pounds.—*Boston Medical and Surgical Journal*.

IMMIGRATION.—In the four months ending with October, 1891, the immigration into the United States was 198,151; in the same four months last year it was 139,315. The immigration in October, 1891, was 54,182; last year in the same month it was 16,428.—*Ibid*.

Special Notices.

LOSOPHAN IN DERMATOLOGY.—Losophan (or tri-iodocresol) has certain definite indications in dermatological practice which specially commend it to physicians. For instance, as stated by several recent observers, it has proved to be of the highest value in mycosis microspora, or facial mycosis tonsurans, in which it gave prompt and decided cures. In folliculitis barbæ, or sycosis vulgaris, Losophan, in one-per-cent ointment or solution, gave excellent results. In some cases 2 and 3 per cent compounds were employed to advantage. Some of the cases, which were said to have long resisted other treatment, were cured in from 18 to 20 days. The remedy is an energetic stimulant, but does not irritate except the quantity used be too large. In some cases, where the remedy was discontinued on account of the irritation produced, it was found later, when weaker applications were employed, that the lesions got well. In pityriasis versicolor complete cures were made with a few applications with a brush of 1 and 2 per-cent solutions. The same results are reported from the use of Losophan in eczema siccum. In some cases of papular eczema, also, the result was most gratifying. It was found that Losophan is the best remedy we have for prurigo, and it either cured or greatly relieved all cases. In scabies Losophan acts more promptly than the usual remedies. It was used in 2 to 3 per cent ointment. Pediculosis capitis and pubis were cured by one-per-cent solutions of Losophan, to which 25 per cent of vinegar was added. It is thought that this remedy will be of exceptional value in the dermatoses determined by epizoa.

I desire to add my testimony to the efficacy of Cactina Pillets in heart disease of various forms. I have under treatment a case of essential paroxysmal tachycardia, result of excessive tobacco chewing, in which the only remedy that gives relief is Cactina Pillets. I have used them with signal success in various forms of functional and organic disease.

JOHN A. ROBISON, A. M., M. D.,

Professor General Medicine, Post-Graduate School; Adjunct Professor Practice Medicine, Rush Medical College; Attending Physician Presbyterian Hospital; Spec. Throat, Nose, and Chest.

CHICAGO, ILL.

THE AMERICAN PRACTITIONER AND NEWS

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NO. 5.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

THE PRESENT STATUS OF URETHRAL SURGERY.*

BY E. R. PALMER, M. D.

Professor of Physiology and Pathological Histology, University of Louisville.

I have taken as my subject this evening The Present Status of Urethral Surgery. Otis published his first case of successful urethrotomy with the Otis instrument in the New York Medical Journal in 1878, and it may be said that in about the year 1883 the craze of promiscuous internal urethrotomy struck this country. That Otis has done much good work, and has contributed some valuable and vital information to genito-urinary surgeons is beyond peradventure, but that the operation has been very much misused and very much abused, and very widely and unwisely applied, is also beyond peradventure. In June, 1890, I reported fourteen cases of successful internal urethrotomy for close stricture at the bulbo-membranous junction without perineal section. When Otis went abroad early in 1880 and advocated his operation on the principle that all gleet was dependent upon stricture, that all stricture could be cured by internal urethrotomy, I may say that the foreign surgeons almost without exception opposed his doctrine, and notably the English, among them Mr. Harrison, who declared that it was an unsafe, dangerous, and unsurgical procedure to cut stricture of small caliber by internal urethrotomy without at the same time making a counter-opening in the perineum so as to permit the escape of urine and to prevent the danger of hemorrhage into the bladder. As before

*Read before the Louisville Medico-Chirurgical Society, January 20, 1893.

stated, in 1890 I reported fourteen cases of urethrotomy for close stricture at the bulbo-membranous juncture without external urethrotomy, and without a single complication, and with a permanent curative history.

At the meeting of the State Society in June last I reported twenty additional unselected cases of the same operation with the same history, and I have here copied from my case book for 1892 a list of fourteen more cases of operation for close stricture in men who could not urinate except with the greatest difficulty, and in some cases could not urinate at all, where the catheter even could not be passed; fourteen additional cases of urethrotomy without external urethrotomy, and in these fourteen cases a history of complete cure in each case. At the meeting at Altoona the opinion of nearly every one present was to the effect that Harrison's operation, namely, the operation through the perineum, should be done jointly with internal urethrotomy. Last June, at the meeting at Richfield Springs, N. Y., Dr. Taylor made the statement that he was entirely in accord with me in the belief that the operation for close stricture in the urethra could be safely done without perineal section, with as much assurance of permanent curative result as if the operation advocated by Harrison, viz., the opening of the perineum into the membranous urethra, was done at the same time as the operation for internal stricture. So that I feel, with a report now of something in the neighborhood of fifty cases without a solitary case of hemorrhage into the bladder, without a solitary case of complication of any sort, and these unselected cases running anywhere from twenty-one to seventy-four years of age, I feel that I am safe in claiming that there is no necessity for opening the perineum when it becomes evident to the surgeon that it is necessary to do an operation for close stricture of the urethra. The most important thing about operations for stricture of the urethra is the proper classification of cases. It goes without saying, that there are men here to-night who would continue to discuss until daylight as to the most desirable mode of treating urethral stricture as between dilatation or divulsion or section by the knife. Beyond any question a great many men have very unwisely cut the urethras of men suffering with stricture, and beyond all question one of the results of unwise cutting of the urethra for stricture is impotence and a more or less permanent deformity of the penis during erection. Beyond any question the operation is being done too often and very unwisely by men who claim that all cases of unsymmetrical urethra or of gleet

should receive the knife. I think it has never been emphasized as it should be that the law of inverse ratio is nowhere more positively exemplified than it is in urethral stricture, namely, that the worse the stricture the better the result. When I first began working in the matter of urethral stricture I cut nearly every thing where there was any contraction or any irregularities that the *bougie a boulé* would detect. I did not believe there was much virtue in the treatment by sound for permanent cure of stricture. Since then, however, I have changed my practice, and never cut a stricture until it has been demonstrated that it can not be cured by dilatation or until it has become an extreme case of close stricture. I now seldom cut a stricture of large caliber, but do cut all close caliber strictures, and, as before stated, the worse the case the most certain and permanent the good result. Before showing one or two instruments I want to emphasize what I have just said by reporting two or three cases.

CASE 1. Bank clerk came to me with impotence, with the statement that he had never had a proper erection in his life, that he had been under medicine and under urging in the way of becoming self-confident, etc., attempting to demonstrate to himself his manhood. He had completely failed in this, and stated that he absolutely never had any venereal connection with any woman; that he had an abundance of opportunities in this direction, but had never been able to have a normal erection. I made an examination of his urethra, and about one inch and a half back I found a stricture that almost completely obstructed the passage. I was able after repeated attempts to introduce a very small bougie. After making a careful examination I made the diagnosis of mechanical obstruction that I believed prevented the inflation of the blood-vessels of the glans; and while I was not convinced that it was a stricture properly speaking, still I believed there might be a cure in this case by the splitting of this obstruction, so I with much difficulty passed an Otis instrument, believing that the necessity of the case demanded it. After splitting the obstruction freely I was able to pass a No. 32 curved sound without any difficulty, and afterward passed a No. 32 straight sound. This operation was done three or four months ago, and he reports to me now that he can not only command an erection, but has also had satisfactory sexual congress. He is a very intelligent, rather intellectual, well-developed young man who has reached his twenty-sixth or twenty-eighth year, and had this trouble, which was probably due not to stricture, but to a neoplasm in the urethra. Of

course the question of removing it by other means as a better surgical procedure is one of considerable importance.

CASE 2. Sometime ago a man came to me, from an interior town, with a perineal fistula, the result of a perineal operation for stricture of the urethra. The stricture, which still existed, was promptly cut with the Otis instrument, and as there was considerable shock following the operation I gave the patient a drink of whisky. He said to me, "Doctor, you do not realize what you have done," and I replied that I realized that I had cured him of a very serious trouble, as I believed that the fistula would close. He then remarked that he never took one drink of liquor without getting on a big spree. I told him that he would not get on a spree in this instance, and to be sure that he did not I took him to the train and saw him safely off toward home. He stopped at Lexington and went on a drunk for about a month. However, the fistula closed, and I understand he became entirely well.

CASE 3. Another case almost parallel with this, as regards the nature of the deep stricture, was one that Drs. Roberts, Yandell, and Rodman had been dilating for a year, and perhaps more. The stricture could be dilated up to a No. 32 sound, and then in a very short time would contract again so close that it was almost absolutely impermeable. In this case the cutting operation was done without perineal section, and the man got well without any unfavorable symptoms at all.

CASE 4. The next case was one that Dr. Roberts also saw. A man who had a close stricture at about the bulbo-membranous juncture was taken down with a violent fever, and after recovering from the fever had a perineal abscess resulting in a permanent perineal fistula which some doctor in Indiana operated to close. When the patient came to me the perineum was gaping widely, with some of the stitches still *in situ*. Two well-marked strictures were found in the urethra, which were promptly cut and the fistula closed, the patient getting entirely well without further operation.

CASE 5. A fire insurance man aged seventy-four years came to me stating that he had had stricture of the urethra for over fifty years, a prominent homeopathic physician in the city having told him that he had an enlarged prostate. An examination showed that he had a perfectly normal prostate, but had eight strictures of the urethra, one right back of the other. A careful examination of the urine revealed no disease of the kidneys and no abnormal condition except the strictures, the patient having to rise frequently during the night, urinating at all

times with extreme difficulty. The operation of urethrotomy was done without perineal section, and the man is now perfectly well. He is entirely cured, with the exception that his expelling powers are not as great as they would be were he a younger man.

In regard to hemorrhage into the bladder in these cases, Keyes states that if you have a clot in the bladder do not interfere with it. If there has been a clot in the bladder or hemorrhage backward in any of the cases I have operated upon I am not aware of it. I have simply reported these cases to prove or in emphasis of my firm belief that it is not necessary to put patients of this character in bed for two or three weeks, as will be the case if you open the perineum.

Now, in the rapid progress of urethral surgery comes the question of the urethroscope; and as the elder Otis was a firm advocate of the doctrine that all gleet was dependent upon stricture, and all stricture called for the knife, so the younger Otis comes to the front with the most perfect urethroscope that has ever been devised, by means of which we are enabled to explore the urethral canal and definitely locate the existence of any stricture or neoplasm and any other conditions which may exist that can not be cured simply by internal urethrotomy.

We all know what the experience has been in Louisville with the cystoscope. It has been previously expressed in this Society that it is not the most reliable instrument in the world. I think, however, that the urethroscope will come into quite general use. Without mentioning any names, I may say that three or four of the prominent young men in this city have been recently entirely cured of persistent urethral trouble by its means. By its use the exact location of the ulcer or inflammation can be determined, and the proper solution can be applied directly to that point. I think this fully demonstrates the fact that the improved Otis instrument is of value not only in stricture, but in other conditions which we find in the urethra equally as serious as stricture. By means of a converter applied to the ordinary incandescent house light a very brilliant illumination may be had.

My assistant, Dr. Windell, will take pleasure in demonstrating the Otis instrument to you in the adjoining room.

LOUISVILLE.

THE DOCTOR, A GENTLEMAN.

BY T. B. GREENLEY, M. D.

In speaking of a physician as a gentleman I do not mean simply a finely-dressed man, nor go so far as to claim he should be a Chesterfield in manners, nor a Beau Brummel in dress, nor even a fantastical Alcibiades, with his canine follower, but in every respect a gentleman in the true acceptation of that term. Of course the term has various significations, according to the country you may be in or speaking of. In this country it means a man of good manners, pleasant address, social disposition, and an honest man. But a physician should possess more than these qualities; he should be a man of kind, sympathetic feelings, and liberal in character. We might cite as a fair sample a man of our own guild, the celebrated and venerable Autocrat of the Breakfast Table, Dr. Oliver Wendell Holmes.

In England the term gentleman has a different signification from what it does with us. In that country it means a member of the aristocracy, with but little regard to his personal qualities.

A physician, however, should occupy a high plane in the community in which he lives, and so conduct himself as to be worthy not only of the confidence of his patrons as a physician, but also as an example for his neighbors to imitate. He should, if possible, be well informed on most ordinary subjects, especially such as his friends are interested in, and thereby be able to render advice and instruction when called on.

As a rule the family doctor is looked up to as a man who should know something of almost every thing, and is frequently asked for information on various subjects. In a few words, the doctor should not be a fool on any subject.

But the principal reason inducing me to write this paper is to say a few words in regard to the social and professional status existing among many members of the profession. Unfortunately for good fellowship among our fraternity there exist unkind feelings, engendered no doubt in many instances from slight causes, and again in other instances without any cause at all, if the matter was properly investigated. Sometimes this bad feeling is brought about through the love of gossip or tattling by enemies on one side and pretended friends on the other, which has not the least foundation in fact. But, unfortunately, in other instances there exist true grounds for unkind feelings between

medical men. And right here we find lacking those characteristics which go to make up the true gentleman.

It should be understood by every man entering the medical profession that it is not one of competition in trade, where tricks and misrepresentation can be practiced with impunity, but he must regard it as a noble calling, wherein a member is to be governed by an honorable code of ethics, which should never be violated. In fact I have always thought the Code of Ethics governing medical men, as it pertains both to the etiquette which should exist between themselves as well as the relations they sustain to the public, should be especially impressed upon the minds of the students, and believe, were this the case, many practitioners would avoid doing many things which are unpleasant to each other, and thereby preserve that friendly and social relation which should exist among all medical men.

On account of unfriendly feelings existing among neighboring physicians, especially in the country, many times consultation is refused, when the sick man is compelled to send some distance for a friendly compeer to meet his family doctor, thereby involving greater expense.

How often do we find it the case that in small towns where two or more physicians are located they are hardly on speaking terms. This fact soon becomes known to the public, and partisans of each physician will soon spring up, taking sides with their favorite doctor. These factions may soon engender strife and bad feelings among themselves, and intensify that already existing among the doctors.

This condition of things is unfortunate for any community, and should always be avoided. One may ask, What connection can there be between a condition of affairs as described and gentlemanly deportment? It requires many traits of character to constitute a gentleman, one of which is suavity in manners. Do nothing to offend your neighbor in word or action, and a state of friendship will likely be maintained. Believe nothing you hear that your neighbor has said or done respecting you until you have satisfactory proof of its truth. Many friends have been made enemies through gossipy inuendo, without any foundation in fact. If a medical brother should, in his relations to other practitioners, violate the Code of Ethics, he should be reprimanded in a gentle manner, and if he is a good man he will not repeat the offense.

There are some things connected with the Code of Ethics that should regulate etiquette between medical men that might be regarded by

young practitioners as so trivial in character as to be violated with impunity. They may think it no harm to solicit patronage, even in families who employ another physician; or they may regard it a harmless matter to advertise themselves as superior to their neighbors; or to give it out that they have a great deal to do even when there is but little sickness. Some go so far as to employ partisans to sound their praises as skillful physicians whenever opportunity offers.

These matters look like small things among the people, but are very repugnant to the feelings of a sensitive physician, and are regarded by him as tricky in character and unbecoming a true gentleman. No doubt many young men in the profession, in the outset, are so anxious to succeed in practice that they regard these offenses against the Code in the light of small matters, and if properly tutored could be reclaimed from such violations.

But unfortunately we now and then meet with a man who is entirely devoid of any compunction of conscience as it respects the violations of the Code. A few of this class I have had the misfortune to meet during my protracted practice, but am glad to say they have been but few in number.

I believe, however, that many members of the profession are unfriendly with each other on very trivial grounds, and that if proper interviews were held amicable relations could be restored. There is nothing more unpleasant to my ears than to hear my medical brethren talk disparagingly of each other, especially so when I regard the parties involved as my particular friends. It has been a rule with me since I became a member of the profession, now nearly a half century ago, not to speak slightly of any brother member. If I can not say a good word for him I keep silent; but as a rule there are but few doctors we can not say a good word for in some particular; and it always does me good when I can frankly speak in praise of my medical brother.

I think if we all could take this view of the matter, and practice it, that there would be much less unkind feeling existing among medical men. In a few words, let us all endeavor to be gentlemen in all the various significations of the term.

ORELL, KY.

SOME COMPLICATIONS OF OVARIOTOMY.

BY L. S. M'MURTRY, M. D.

Professor of Gynecology in Hospital College of Medicine.

More than two years ago Mr. Lawson Tait said that the last words had been uttered on the subject of ovariectomy, the mortality having been reduced to the least of any major operation known in surgery. But ovarian tumors are so common and present such diversity of structure—dermoid, fibroid, parovarian, monocystic, polycystic, etc.—with so many variations and complications that they prove of continuous interest and importance.

There are very few major operations that can be confidently undertaken in very old subjects, operations where there will be a very heavy strain on the system, great danger of shock, and where there will be a great deal of traumatism to vital organs in connection with the operation; all dangers are very much exaggerated in the aged.

1. *Ovariectomy in a Patient of Seventy Years.* Last October I operated for a very large double ovarian cyst in the case of a lady from Kansas, seventy years old. The tumors were so large (I only suspected one tumor when beginning the operation) that they extended to the diaphragm: abdomen distended so that the skin was shining, the umbilicus protruding, and the general condition extreme and distressing. She said that her journey from Kansas to Louisville was the most trying ordeal through which she had ever passed. The operation disclosed very extensive intestinal and bladder adhesions, which are always difficult to deal with, especially in cases where they are old and firm. The pedicle of the large tumor on the left side was one of the largest that I have ever dealt with; it had to be quilted with a double ligature and another ligature around. The patient has since made a good recovery.

2. *Ovariectomy in a Patient of Seventy-two Years.* Another case, referred to me by Dr. J. M. Krim, of Louisville—a woman who will be seventy-two years old in March. When I first saw her with Dr. Krim, we made a diagnosis of ovarian cyst as most probable, although neither he nor I could say positively that it was ovarian, because we could not get any fluctuation in the tumor. We had the patient moved to the Infirmary: she was vomiting, with rapid pulse and high temperature; her abdomen was opened, and we found an immense cyst on one side,

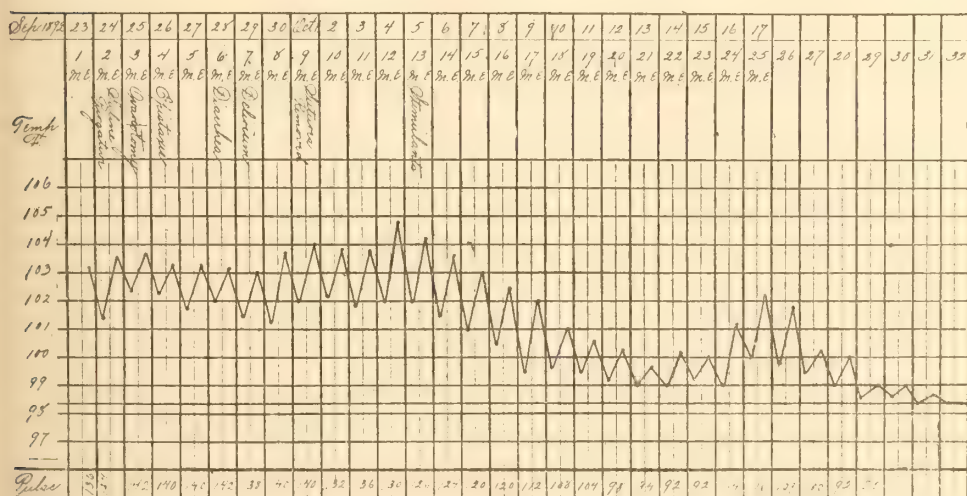
and, like the other case reported, a smaller cyst on the opposite side. The larger cyst was of a dark-bluish color; there were a great many adhesions, and new adhesions were forming. Peritonitis was active around it. After enucleating and tapping the larger cyst I found that the pedicle was twice twisted, the circulation being shut off from the sac; it was sloughing, and peritonitis was established. The interior of the tumor was filled with clots and dark colored fluid, the result of hemorrhage in the interior from obstruction of the circulation by this twisted pedicle. I removed both tumors; the peritoneum was thoroughly irrigated and drained, and she made one of the most prompt recoveries that I have ever known. There was not an untoward symptom of any kind.

These two cases are very interesting as confirmatory evidence of the fact that ovariectomy is the most successful major operation known to surgery. I believe that much of this is due to the fact that ovariectomy is largely in the hands of a few surgeons, and that the statistics of ovariectomy are furnished mostly by surgeons who have had large experience and have acquired results which can only be attained by skillful attention to all details of the operation.

3. *Ovarian Cystoma with Twisted Pedicle and Peritonitis; Ovariectomy in Second Week of Typhoid Fever; Recovery.* I will mention another ovariectomy: A young lady, twenty-one years of age, unmarried, was brought to me from Daviess County, Kentucky, the latter part of October, with ovarian tumor. Diagnosis was clear. She was very ill when she arrived, and when I took her temperature it was 103.5° F., with a rapid pulse. That night she had persistent vomiting, which on the following day became of that character which belongs to peritonitis, green serous vomiting. On the second day I found her in such a serious condition, evidently from peritonitis, high fever with rapid pulse and vomiting, that I decided to operate at once. I found a very large ovarian tumor, extending up to the diaphragm, a multilocular cyst with double-twisted pedicle and with sloughing sac. In separating the adhesions with my finger the sac ruptured, and the pus contained in the tumor ran out over the table. I should judge that at least two gallons of pus and serum ran out of the tumor. As is usual in these cases there was a smaller cyst on the other side. The peritoneum was thoroughly irrigated with about three gallons of water, and the patient put to bed with very considerable shock. She reacted very well, and the pulse came down to 120 in six hours after operation.

The next morning the nurse telephoned me that the patient was bleeding at the nose. I thought this was merely an accidental circumstance. When I took the temperature the morning following the operation it was 101.5° F., pulse still rapid, over 120. She had a red spot on each cheek, and presented a very unfavorable appearance. During the day delirium supervened, and that evening her nose bled again. The next morning examination of the body disclosed rose-colored spots; diarrhea had come on, and I found that I had done an ovariectomy in the midst of an attack of typhoid fever. My friend, Dr. Thos. Hunt Stucky, confirmed the diagnosis of typhoid fever, and regularly visited the patient from this time on to recovery. She went through the course of this disease, but so far as the ovariectomy was concerned the result could not have been better had she been in a perfectly afebrile condition. She was five weeks in the Infirmary. It was a very severe attack, the temperature reaching so high as 104.6° F.

She has now fully regained her health. I append the chart showing the pulse record and temperature observations.



Name and age of patient: Miss L. S., 23 years. Nature of disease: Typhoid Fever, Ovarian Cystoma, Twisted Pedicle; Ovariectomy.

This case illustrates another complication of ovariectomy, and still further confirms Mr. Greig Smith's statement that it is the "most successful major operation in surgery."

LOUISVILLE.

Reports of Societies.

THE LOUISVILLE CLINICAL SOCIETY.*

Stated Meeting, December 27, 1892, Dr. I. N. Bloom, President, in the chair.

Dr. A. M. Vance: I simply present this patient, boy, aged eleven years, to the Society to show the result of amputation at the hip for suppurative hip-joint disease, and resection of the eighth rib for effusion in pneumonia. The history of the case is about as follows: I first saw the patient in September, a year ago, and diagnosed suppurative disease of the right hip-joint. As is often the case in children of this age the course was rather rapid, an abscess forming in Scarpa's space with evidences of excessive bone disease. Aspiration was practiced several times without any great success. In March, 1892, the boy was put in the Children's Hospital, and the abscess opened and irrigated; the opening was followed by a long season of sepsis without any reparative action whatever going on. At the time the abscess was opened I discovered that the partition of tissue between the femoral artery and the abscess cavity was exceedingly thin, therefore no drainage-tube was inserted, fearing sloughing would take place; and I prognosticated at that time possible rupture of the femoral. After a month of high fever, excessive discharge of pus from the abscess, hectic condition, etc., I was called by telephone to the hospital at three o'clock one morning, the message being that the patient was bleeding profusely. Upon examination I found the femoral artery had spontaneously ruptured into the abscess sac, the patient being thoroughly exsanguinated. The artery was ligated by candle-light, the leg wrapped in cotton wool and elevated. At the end of forty-eight hours the foot was gangrenous, and notwithstanding the fact that the patient was barely alive (temperature 104.5° F., pulse beyond counting), amputation at the hip was decided upon. The operation was done at once, Dr. W. C. Dugan assisting, Dr. Guest administering chloroform. When the patient was put upon the table for operation his pulse was hardly perceptible at the wrist, probably 170 to the minute. The femur to the extent of about four inches was found to be very much diseased, the acetabulum also being involved. I

*Stenographically reported by C. C. Mapes.

did not make any attempt to clean it, believing that nature would do so, the object being to get the patient off the table as soon as possible, owing to his extreme condition. The time consumed in operation from the moment anesthesia was half complete, until the dressings were applied and the patient put in bed, was about nine minutes. Whisky and nitroglycerine were given hypodermically after the operation; reaction came on slowly, convalescence gradual. There was very little hemorrhage during amputation, the femoral having previously been ligated on account of rupture.

About two months after this he was taken suddenly sick, and it was found upon examination that he had an attack of double pneumonia, both lungs being extensively involved. He was still in a very hectic condition, having recuperated but little from the state of depression at which he had arrived owing to the amputation, and his case was given up as hopeless, all effort toward helping him being discontinued, except to make him as comfortable as possible. However, the crisis came on the third day after the attack, and he slowly began to convalesce. His right lung cleared up very nicely, but the left remained dull, apparently solid. Upon careful examination we found that there was an immense accumulation of fluid in the left side of the chest, which was tapped three times. At the first aspiration we removed three and one half pints of fluid, the second time two pints, and the third time two pints, a pint of which was pus. The heart at this time was beating away over to the right side, showing the extent of the effusion. The condition of the patient was now equally as alarming as before the amputation, and as the aspiration was doing no apparent good, I advised that another chance be given him, and excision of a portion of the eighth rib be done. This operation was performed about a week after the last aspiration, the chest being thoroughly washed out with hot water, and two large drainage-tubes inserted. Time consumed in this operation seven minutes. I will mention that in irrigating the cavity of the chest it was done in a very thorough manner, throwing the water in through one tube it coming out through the other, each inspiration working like a force pump. The drainage-tubes were allowed to remain in about ten days, then removed, and a pledget of gauze inserted, which was also removed in a few days, the wound healing perfectly. The patient has entirely recovered the use of his lung, as will be observed by deep inspiration, and there is bony renewal of the excised portion of rib. I think this will be obtained in nearly all cases, if the precaution is

taken, as I did in this case, to slit the periosteum, turning it back, simply removing the rib itself, leaving the periosteum intact.

I consider this a very remarkable case, the patient having gone through two grave operations and double pneumonia inside a period of three months. There is one thing certain, that without hospital advantages the boy would probably have died in either operation. There is now no evidence of tuberculous trouble, and I think his ultimate recovery is assured.

Dr. W. C. Dugan: I had the pleasure of assisting Dr. Vance in the operations referred to upon this patient. I consider it one of the most remarkable cases on record. I also think that a case of this kind is extremely rare. Many would not have attempted an operation in such extreme conditions. Rapid surgery saved this boy's life.

Dr. Vance: I was called on the 29th of last November by Dr. Leachman to see a boy who had had since last March an enlarged spleen. The patient was about seventeen years of age, and his spleen had grown gradually since it was first observed in the early part of March until the time I saw him, when it was enormous. I was called to the case to stop hemorrhage from the nose, which had been going on for forty-eight hours, and the boy was pretty well exsanguinated, showing his grave condition. Dr. Cheatham saw the case, and the boy was still bleeding, although I had plugged the nose from the front and posteriorly. The boy eventually died of hemorrhage from the whole alimentary canal. He passed large quantities of blood *per rectum*, threw it up from the stomach, much more than could possibly have come from the nose. Diagnosis had been made of leucocythemia. A *post-mortem* was obtained, and we secured the spleen, liver, and suprarenal capsule. The spleen and liver are exhibited for your examination; you will notice that both organs are enormously enlarged, the spleen being over a foot in length, and weighed when removed nearly twelve pounds. The kidneys were also very much enlarged. Dr. Louis Frank has made several microscopical sections of both the liver and spleen, which I have asked him to bring here to-night for your inspection, and upon which I hope he will give us some further information with result of his repeated tests.

No. 2. I was called by Dr. Baker on December 16th to see a man, thirty-two years of age, butcher, who had been suffering for twenty-four hours only with all the symptoms of acute appendicitis. He gave the history of having had some bowel trouble before, always preceded by

diarrhea, as was also this attack, but had never been laid up. His temperature was 103.5° F. when I saw him, and he had had one rigor a few hours before. His pulse when Dr. Baker was first called was only 59 to the minute, and when I saw him, despite his fever, it was 72, which is a very curious element in the case. I advised immediate operation, and assisted by Dr. Dugan and Dr. Baker the operation was performed, Dr. Tuley giving chloroform. I exhibit here the specimen removed, which is a very curious appendix: it was on the verge of perforation; was adherent to every thing around it, and particularly to the omentum, which had formed a sort of wall or sac around it, and when I first introduced my finger and pulled the appendix up I thought it was very much enlarged. The appendix was tied off at the junction with the cecum through reasonably good tissue; all of the omentum which came in contact with the appendix was removed; the wound closed with silk-worm gut, a glass drainage-tube being left in twelve hours. The man made a rapid recovery. I think, if operation had been delayed twenty-four hours longer, he would have had general peritonitis.

Dr. Louis Frank: The exact measurements of the liver and spleen exhibited by Dr. Vance I do not remember, but they were much larger at the time of removal than at the present time, the liver especially having become considerably macerated. As yet I have not examined the kidneys nor the suprarenal capsule. In the spleen, however, I found upon microscopic examination what appeared to be white infarctions, and with these some spots that appeared to be cheesy in character; these latter I found, instead of being degenerated tissue, were made up of dense connective tissue. The capillaries and larger vessels of the spleen were found to be filled with white blood corpuscles, and no red ones at all. In the several sections made not a single red blood corpuscle could be found. In the liver there is some increase in the connective tissue, which is due to round-cell infiltration, polynucleus cells being also found, giving a true connective tissue formation, caused probably by cells that had found their way through the thin vessels into this connective tissue. Also the capillaries between the individual cells were very large, these cells being crowded to the sides and the capillaries filled in with white blood corpuscles. The cells in section of the liver examined had undergone no degeneration at all, as we might expect to find, from pressure; they were perfectly normal cells of the same size that we have in ordinary live tissue. The liver was rather soft when

removed, a great deal more so than we expected to find. The spleen when removed weighed about eleven pounds, the liver a little over ten pounds. An examination of the blood taken from this patient was made by myself, also by Dr. Weidner, some weeks before death of the boy, and then the proportion of white and red blood cells was two to one. This is very high, the ordinary proportion being six hundred to one. I have no doubt, if the blood had been examined just before death, the proportion would be even less than this.

Dr. Dugan: I saw the patient referred to by Dr. Vance in the latter part of February or early in March, and he then had a large tumor extending down into the pelvis. The question of diagnosis in these cases is one of great importance; it is very simple when you examine for the notch, which is oftentimes overlooked. The notch in which the large vessels enter is always very marked and can be easily outlined. When this boy came to me the question was whether he was suffering from leucocythemia, or whether it was malignant disease. I was inclined to the diagnosis of leucocythemia, and sent him to Dr. Simon Flexner; he being absent from the city at the time, his brother made an examination of the boy's blood and found the white corpuscles one to two. Of course when he made this report I decided it was not malignant in the sense that we usually use the term "malignant," and refused to have any thing further to do with the case in a surgical way, and he went back to his physician.

About a year and a half ago I was called by Dr. Larrabee to see a lady in this city who had a very large spleen, in fact one which nearly filled the abdominal cavity, and asked if I thought it advisable to remove it. At first I thought very favorably of its removal until I went home. I then consulted all the authorities on the subject that I had, and found there was no case on record that had recovered after such operation, and of course changed my mind. I made a *post-mortem* in this case, removing the spleen, which weighed between seventeen and nineteen pounds, if I am not mistaken. In this case there was no apparent change in the liver or any other organs of the body. There are three forms of this disease: one form involving the medullary canals of the long bones, another involving the lymphatics, and the third involving the spleen. The pathology of the disease remains to be written, and such cases are universally fatal, most of them dying by hemorrhage. This disease is not so rare after all: I know of four cases in this city within the last two or three years, and doubtless there are others.

Dr. W. H. Wathen: I wish to emphasize the practical value of conservatism in the treatment of the case reported by Dr. Dugan. Surgery of the spleen has been very successful in many particulars, considering the apparent difficulties with which we have to deal, and probably the desire to operate upon enlargements of this organ has caused men to perform the operation where it was contra-indicated. There are probably very few surgeons engaged in abdominal work who appreciate practically the fact that there is no case, at least, I say, no well-authenticated case, where extirpation of the spleen for leucocythemia has been successful. For that reason I say this case is especially opportune in bringing out this feature so that the profession may understand it.

Dr. J. W. Irwin: I regard these cases more in the light of medical curiosities than any thing else. I have seen two cases of this nature within the last twelve years. The first was in an adult who lived in a malarious part of the country, and it was thought for a long time that he had an ague-cake. When the case came under my observation the spleen filled nearly the whole of the abdomen, which gave the appearance of a person in the last stages of ascites. Of course the patient died, and a *post-mortem* was held; the spleen was found to weigh twenty-nine pounds, the liver weighed eight pounds.

The next case which came under my observation was in this city, less than one year ago, in a child under one year of age, which was the offspring of healthy parents. The child had become so thoroughly anemic that two or three physicians had been called, and none of them would venture a diagnosis. One physician said it could not be cured; another said he did not know what the disease was. I made a careful examination and found the spleen very much enlarged, with apparently no enlargement of the liver. It was profoundly anemic and died. I am sure that the spleen filled three quarters of the abdominal cavity, it was so enormously enlarged notwithstanding its tender years. All that I could do was to prognosticate death.

Dr. J. M. Ray: Two years ago last September an Irish lad, about nineteen years old, consulted me about his nose. He was a great politician, and on election night had been hit on the bridge of the nose, the result of which he had a sinus leading down to the septum, and on probing it I found a piece of necrosed bone. By anterior rhinoscopy an accumulation of pus was found between the bone and periosteum of the septum. I made a small incision into the pus cavity and let out quite an accumulation; hemorrhage was very slight at the time. That

afternoon I was out; on returning about six o'clock I found the entire office floor covered with blood. My servant told me that the gentleman whose nose I cut in the morning had returned, and his nose had bled so furiously that he fainted and a carriage was called to take him home. I immediately went to see the patient, and found him with the most persistent case of nosebleed that I ever saw. I plugged it behind and in front, then the blood would come out of the sinus. I worked with him for three or four hours, and at last succeeded in stopping the flow. He came to my office again after four or five days, and I then began to investigate the cause of the hemorrhage. He told me that at one time he had a tooth extracted and had considerable hemorrhage. The case then passed from under my observation until the following summer. In the mean time I understand he remained in very good health. The following summer he consulted me for intense vertigo and deafness. In testing the hearing the tuning-fork pointed to it as of nervous origin. He gave me the history that the deafness had come on suddenly about a week before I saw him. This, of course, put a new aspect upon the case, and I began to further investigate; still I did not make a diagnosis. I noticed at this time he did not wear the top button of his pantaloons fastened, and upon questioning him he said that his abdomen seemed to be swollen so that he could not button his clothing. I then made an examination of the abdomen and found the spleen very much enlarged. I was led to make an examination of his eyes by his profound deafness and the enlargement of the abdomen. On examining with the ophthalmoscope I found a typical illustration of a cut in Jaeger's Atlas of Ophthalmology, a pale, straw-colored fundus covered with peculiar patches and hemorrhages. Both eyes were involved, yet the sight seemed to be perfect. From these symptoms I made the diagnosis of leucocythemia. Subsequently, I believe, both Dr. Weidner and Dr. Frank examined the blood and pronounced the trouble leucocythemia. The man went on from bad to worse, growing weaker and weaker, and on several occasions in attacks of vertigo had fallen. He came to me one day and said that he had something on his hip that he would like to show me. Upon examination I found an immense hematoma, probably as large as your double fist. In his vertigo he had fallen, and said this lump appeared on his hip afterward. This disappeared in a few days, and eventually he began to bleed from the gums and from the throat; in the mean time his abdomen had continued to increase in size until it was as large as a woman's at the ninth month of pregnancy, with

distended veins running over the abdomen; his feet also became so swollen that he could not walk during his last two or three weeks' illness. Hemorrhage continued from the gums, then from the nose, then he began to vomit blood, then purge blood, and finally died. I tried to obtain a *post-mortem* in this case, but was unsuccessful on account of objections on the part of his family.

While this patient was coming to me I saw in one of the medical journals where arsenic was recommended in cases of this character. I prescribed this drug, which gave him more relief than any thing; he grew stronger, and seemed to suffer less inconvenience from distension of the abdomen while under Fowler's solution.

Dr. L. S. McMurtry: The second specimen exhibited by Dr. Vance is a very interesting specimen to me, and the subject is one that I do not think has ever been very thoroughly discussed in the Society. We have had several cases reported, but I do not believe the subject has ever been taken up methodically and discussed as it ought to be on account of its importance. I remember, two years ago this winter, I attended a meeting of the Surgical Society and reported two cases of abdominal section for appendicitis with recovery. In the discussion that evening one of the Fellows implied skepticism as to the existence of such a disease, and expressed opposition to treatment by operative interference. I believe at that time there had not been a single operation for appendicitis, as far as I know, done in Louisville. Since that time the operation has been done many times in this city; it has been done by Dr. Satterwhite, by Dr. Dugan, by Dr. Vance, and by others. It is the most common cause of peritonitis in the male, and if we will take the Health Officer's reports as they appear in the daily papers every Monday morning, it is the exception not to find one, two, or three deaths reported from peritonitis, which means that there was no diagnosis made, because peritonitis is of itself not a disease. In cases of appendicitis we have yet to improve in regard to early operation. Now this specimen exhibited to-night had adhesions around it, but there was no extensive suppuration, and the operation was done before the pulse had run up, and before the system was saturated with septic products. There is one particular fallacy in regard to appendicitis that I would like to call especial attention to. We often hear the argument against operative measures, that one case (or perhaps a dozen cases) has been treated by conservative measures, opium, poultices, etc., and recovered. And one case may be reported by five or six different physicians as

having recovered, which is operated upon by the seventh physician. This will go on record as six cases of recovery from appendicitis without operation, when the patient has never recovered, and has been operated upon by somebody else. These statistics are used as an argument against operative interference, when the patients have passed into other hands for operation. A patient may have recurrent attacks of appendicitis, and we never know when perforation will occur. I recently operated upon a little girl, six years old, with general suppurative peritonitis, where the appendix had sloughed off and came out with the irrigation water. The operation was done on Saturday at eleven o'clock, and the girl was at school on Wednesday preceding. We never know when we have a case of this kind, and the practical point is not only that operative treatment is the proper procedure, but we must take one step forward and let the surgeon see the case sooner, let the operation be done sooner. If it is done early, the majority will recover. The success of the operation in the majority of cases depends upon the time after the initial symptoms of the attack until the operation is performed. I think the Society can with advantage discuss this very important subject, and formulate something like a definite date for operative interference—those symptoms which indicate immediate operation. In the case reported by Dr. Vance it was operated upon right in the golden moment. Only to-day a case came under my observation where the patient was passing berry seeds, etc., through an abscess that had broken through the abdominal wall from the appendix, indicating how common this trouble is, and what risks are incurred by delay in operating. The operation itself, when skillfully performed, is not of itself dangerous; whereas delay, with uncertain diagnosis, is always dangerous in intra-abdominal diseases.

Dr. Wathen: This case illustrates the simplicity in operating successfully in some cases of peritonitis of appendicular origin. The dangers in operations of this character with an experienced surgeon are practically *nil*; but in other cases the operation is very difficult, and the results are often necessarily fatal because of extensive involvement of the peritoneum and abdominal viscera. This is a subject that has been discussed and written about *ad nauseam*, every leading surgeon is practically familiar with the literature of the subject; and while there are some very beautiful results the enthusiasm of some surgeons has pushed the pendulum too far; but during the last two years it has begun to swing back. The man who does not go too far in either direction would

probably be the safer man for this kind of work. Again, it is impossible to always tell whether the trouble is appendicular. Every surgeon of experience in abdominal work has observed cases in his operations that have been diagnosticated appendicitis, where the appendix was not involved and the case was one of peritoneal trouble of some other origin. Again, there is no denying the fact that there are many cases where the subjective and objective symptoms plainly indicated appendicitis more marked than in many cases operated on where the patients have recovered and are now, years after the attack, apparently well. I know of several such cases. No doubt there are many cases where death has resulted because the surgeon had not seen them sufficiently early, because of delayed operation. On the other hand, there are cases that are not surgical.

T. C. EVANS, M. D., *Secretary*

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.*

Stated Meeting, January 20, 1893, Dr. F. C. Simpson, President, in the chair.

Dr. A. M. Vance: The specimen I exhibit here is an ovarian polycyst and the other ovary removed from a maiden lady forty-two years old. The only point of interest is that her attention was never called to the tumor.

Dr. W. O. Roberts: What finally attracted attention to the tumor?

Dr. Vance: It was discovered by her physician, who was called on account of some pain during menstruation. The tumor contained a number of cysts, and the cystic fluid was very thick. The whole operation was done in eighteen minutes.

Dr. Roberts: Two years ago I saw a young man with a chancre on the penis, which was followed by a bubo in the right groin, which of course went on to suppuration and was lanced, and there was no further trouble until two weeks ago. He came to my office with an enlargement in the groin, which he said came on after pretty hard work at the store in which he had done some heavy lifting; that he felt some pain in the groin, and in a short time it began to swell. When he came to my office the enlargement was about the size of the first joint of my thumb, and quite tender. I put on a compress and bandage, which he

*Stenographically reported by C. C. Mapes.

wore for ten days; but instead of improving the swelling continued to increase, and finally I made a free incision into it and a considerable amount of pus escaped. The incision was very long, over two inches, and the suppuration seemed to be from around the gland instead of from the gland itself. I then put on an antiseptic poultice and bandage, continuing this treatment for three or four days. The gland seemed to increase in size, and all the time the suppuration continued to come from around it, and I thought possibly I had not gotten into the gland. I then held it with a pair of forceps and cut through the center, but no pus came away. I then put the patient under chloroform and removed the entire gland. I exhibit it here for your inspection. It is very much shrunken now from being in alcohol. It was dissected out with my fingers, leaving a very large cavity.

Dr. E. R. Palmer: I have read in the last few days a paper from a writer who wrote as if he thought he had discovered the only way to treat bubo with all its complications, and the only point he makes of any particular value is that peri-adenitis is often antecedent to suppuration of the gland itself, and he advocates, instead of early opening, the very latest opening possible, in order to allow as full destruction as possible not only of the gland but of the connective tissue about it. And then in his advocacy he favors the trimming off under chloroform of the entire roof. This is the old operation, and leaves a broad, wide, and open ulcer which you can curette, clean, and pack, treating so that it will be sure to granulate from the bottom, resulting, as he says, in a smooth and almost normal cicatrix.

We were promised a year ago by Dr. Francis Watson, of Boston, a paper on the treatment of bubo based upon his statements that the ideal treatment of bubo had never yet been formulated; but unfortunately he went abroad and the paper has never been read. And I must say, when it comes to making these enormous openings with view of radical and speedy cure, that you leave the patient in such condition as will certainly cause him throughout his entire after-life to conceal his person, lest the exposure of this broad, flat, or depressed thin cicatrix will tell the story of his previous infection. I think it is a big question, in treating these inguinal abscesses in young men, whether we shall give them a speedy cure by radical and rapid surgery that shall clean out everything, making a wide, open sore, and leave them with a broad mark that will remain with them through life, or whether we should prolong the treatment for a few weeks or perhaps several months, and finally get

them well with only the merest white line to mark the place where incision was made, the skin not having been removed, thus insuring them in later life the precaution against exposure that may come. In treating young men for suppurating groins we are bound to recognize a fact which we all know as doctors in middle life, that it is very important to have a man so that in later life he can throw off his clothes or go to sleep on a hot summer day with the possibility of his shirt getting above his groins without exposing a great, broad, depressed cicatrix such as comes from these extensive operations. In my own work I am not afraid to do radical operations in the groins, and am perfectly willing to do them; but when a young man presents to me with glands of this sort I nearly always procrastinate, and work through small apertures, curetting through them, using peroxide and bichloride of mercury solutions, doing a great amount of hard, tedious work extending over quite a period of time, with the simple idea that a few weeks or even a few months are nothing to a man if in the end he can be cured with such treatment and be in a presentable condition later on in life. Every married man knows, who has lived up to middle life, that a man is liable in his bath and in his domestic life to expose himself very generally, and I have seen cases where these glands were taken out, leaving a large scar, which might have been avoided by proper treatment. Every one knows that by radical treatment in these cases we are apt to get these big scars, and what is the best surgery from a purely surgical standpoint in these cases has not yet been fully determined to be the best practice. I am speaking largely not only with reference to the operation as performed by Dr. Roberts, but with reference to Dr. Rodman, both of whom operate extensively on the groin, and also with reference to the article which appeared in the journal mentioned. This man's idea is to simply first open and evacuate, then at the last moment making a large incision, and with scissors trim off and take out the entire roof and make a large open sore that can be curetted, cleaned, disinfected, and treated with a resulting cicatrix, which comes of course in a short period of time. This usually leaves a pale, hairless, depressed cicatrix, which we ought to try and avoid in young men who have thirty or forty years of married life coming to them afterward.

Dr. C. Skinner: What per cent of buboes suppurate, in your experience?

Dr. Palmer: Syphilitic bubo almost never suppurates; gonorrheal does sometimes, and virulent buboes always. I have had patients

where there was a patch of blue tissue as large as a dollar, which could be lifted up, and that you could get under with your curette or with your probe. Under this treatment, advocated by the writer in the journal referred to, the operator would take a pair of scissors and trim off this entire flap, with the view of getting an exposed ulcer which can be cleansed, disinfected, and curetted, his idea being that the under surface of this diseased skin is filled with suppurative material that contains the bacteria of suppuration, which will keep infecting the tissues underneath. But I believe that this flap can be cleansed, and better results and less scar obtained by not trimming off the roof. By reversing your curette you can curette the entire under surface of the skin. I have done this in several instances until the skin was as thin almost as linen cloth. You can curette in this way, and then by frequent washes of peroxide of hydrogen followed with bichloride of mercury, then by a carefully adjusted compress with spica bandage you can preserve this piece of skin, and the wound will heal, leaving only a very small cicatrix, which can not be discovered without close inspection. So far as the surgical treatment is concerned, it is a very easy matter to make a counter-opening, if necessary, and insert a drainage-tube. I have sometimes found it necessary to do this. Frequently in cases that have previously had suppurating bubo you will find ridges of considerable size left. It has been my experience that these ridges, under constitutional treatment, under cod-liver oil, under hydriodic acid, and under a properly adjusted compress, can be gotten rid of. I believe that the treatment of this condition is a question that will be very largely discussed in the future.

Dr. Vance: Do you mean this talk to apply to glands where suppuration has already occurred before being seen by you?

Dr. Palmer: Yes, of course. I see comparatively few suppurating glands. It is perhaps remarkable that I see so few of them. Many cases that apply to me have passed through the hands of other men.

Dr. Vance: In cases of chancroidal bubo without suppuration do you practice prophylactic treatment of the gland?

Dr. Palmer: In chancroidal bubo I do not believe with the extirpation of the gland you can hope to remove all the infection. I believe that the lymphatics are involved to such extent that the enucleation of one enlarged gland will hardly remove source of infection. In addition to the enlarged and infected gland there is in nearly all cases a peradenitis below and around the gland itself.

Dr. W. L. Rodman: I take issue entirely with Dr. Palmer as to the question of scarring. I think the bad scars he has seen must have been caused by the very practice he advocates. It is only very recently and by a few surgeons that these glands have been dissected out bodily. I think that the operation should be done not only to save time, to get the man out as soon as you can, but for the very purpose of preventing scarring. If the operation is carefully done, the scar left is so small as to be scarcely noticeable. I recalled three or four cases, while Dr. Palmer was speaking, upon which I have operated for enlarged glands (and I would like to have had the patients here to-night), where the wound was closed by deep as well as superficial sutures, and where union took place by first intention. In one case I found that suppuration had already taken place in the gland. It was carefully dissected out bodily without infecting the wound, which healed by first intention, and to-day I doubt if a scar could be seen. I operated upon a man at the City Hospital who had enormous glands in the groin, and there was union by first intention in the same way, and the resident physician, Dr. Tomlin, operated upon the other side shortly afterward, the wound healing by first intention. In this case I doubt if you can see a scar on either side to-day. I would operate for the purpose of preventing scarring. The majority of these cases, as we all know, will go on to suppuration, and we can not prevent scarring if we allow the tissues to break down themselves. If the glands are dissected out carefully and deep suture inserted there will be no trouble at all, and you will have no depressed cicatrix, as you will have should they discharge spontaneously. I think every gentleman here will agree that where you find enlarged glands on the neck or face, and you are satisfied that they are going to break down, it would be very much better to make a small incision and dissect them out, in order to prevent suppuration and formation of ugly, depressed cicatrices we so commonly see in patients who are treated by poultices and other expectant means.

Dr. Palmer: I suppose all men have curious experiences, and simply to emphasize what I am going to say, that I am treating a very large number of cases of gonorrhea seven days in the week, and I do not think I can recollect in eight years' practice five cases of suppurative glands from gonorrhea that I have opened. I have had some pretty large glands in gonorrhea that have eventually disappeared. I believe these very glands Dr. Rodman has opened and found pus in, which, had they been subjected to less radical treatment, would have

disappeared. I have a case under treatment now, a young man who had some femoral glands enlarged from gonorrhea that a doctor in the city, one of the regular members of the profession, diagnosticated as rupture, and who applied a truss for its relief. When the patient came to my office there were two or three openings leading up to a broad, extensive sinus. The overlying tissues were very much diseased, and blue in color. There was also a counter-opening communicating with this sinus that had been formed by the truss. In this case we removed the truss, dilated and curetted the infected portion of the tissues, injecting peroxide of hydrogen, then bichloride of mercury, and treated with anti-septic agents. The patient is doing well, and I think will finally recover without any scar. I do not in my work see one case in a thousand where there are suppurating glands from gonorrhea that need evacuation.

Dr. A. M. Cartledge: What do you consider the pathology of gonorrheal bubo?

Dr. Palmer: You know the statement that Bumm made in regard to the child that died, that the cord was invaded by the gonococcus, and that the gonorrhea had followed the cord up. I do not exactly agree with Bumm concerning the pathology. I believe that bubo is caused by the germ of suppuration. At any rate I do not think the gonococcus does it. It must be the pyogenes aureus, must be the pus bacterium that produces it.

Dr. Cartledge: You believe then that suppuration, which takes place in the inguinal glands in gonorrhea, is produced by the pus-forming micro-organisms?

Dr. Palmer: Yes. I do not think it is always necessary or advisable to open these enlarged glands, but by pressure and careful management you can reduce them without extirpation. I know it is very tempting and is a beautiful operation to go down into the groin and dissect out these glands, cleaning them out thoroughly, carefully stitching the wound, and allowing the patient to get out in a comparatively short time; but it has been my experience that by this treatment there will be more or less scar left as a result, which could be prevented by the treatment I have suggested. I have seen a great many cases of so-called tuberculous enlarged inguinal glands, and believe they should be at first subjected to the same treatment. I want to stand fairly and squarely as an advocate of conservatism in the treatment of enlarged glands. I have never yet seen a case of enlarged glands from gonorrhea that needed extirpation.

Dr. Skinner: I desire to say that I want to stand just as fairly and squarely on the other side of the fence in regard to the treatment of bubo. I think the only plan is to enucleate these buboes as soon as they show any tendency whatever to suppurate or break down. I have been doing this now for some little time, promptly enucleating the enlarged glands at the first appearance of suppuration. In regard to the scar, I want to mention one case to show the effect of an operation for removing a scar and at the same time removing a suppurating gland. Sometime ago a young lady came to me with a swelling on her neck, who in childhood had had a suppurating gland of the neck, which had been opened, leaving a very ugly scar, and one so deep that she had great trouble in keeping it clean. This swelling occurred near the old scar. I told her that I believed the only thing to do was to make an incision, removing the suppurating gland, and at the same time take away this troublesome scar. I did the operation, carefully removing the gland and the old cicatrix. The wound healed perfectly, leaving at first only a small line. This was several months ago, and to-day not the slightest scar can be seen.

Dr. Cartledge: First of all, I think it is impossible to treat all of these cases alike. We are all familiar with the different clinical characteristics of gonorrheal bubo. Where I find surgical treatment necessary I have been in the habit of pinching these usually small abscesses up between my fingers and slitting them open. I do not see the necessity for making a large incision in gonorrheal buboes, and I think they will get well better without it. I seldom make a larger incision than one half inch. They are not specially infective, and with this small incision they get well without any perceptible scar. I believe the tendency to scarring is greater with a large incision, removing the gland. In regard to chancroidal and true virulent bubo, I believe I would agree with both sides, and yet disagree with both sides in the discussion. I believe if the bubo has attained a considerable size, and you can demonstrate the existence of pus, it should be opened and the pus evacuated. But in doing this in a virulent bubo the wound is liable to become infected, and thus prevent its healing. In such cases it may become necessary to remove the diseased glands.

Dr. Roberts: There are certain conditions of the glands of the groin that we know will go on to suppuration. Chancroidal bubo is one of them, another is the tuberculous gland when they become very much enlarged. I believe with Dr. Rodman that the thing to do is to take

them out, and to do the operation before suppuration has taken place. If this is done we are almost certain to get primary union. Even if suppuration has taken place, and you can remove the gland without infecting the wound with the pus microbe, you are almost sure to get union by first intention, and there will be little or no scar. There are other conditions which give rise to these enlarged glands in the groin, in which the inflammation can be relieved by properly applied bandage and pressure, and which will not suppurate. My experience with gonorrheal bubo is, that if I see a case early and can have the patient wear a compress bandage, that they do not suppurate. Where they are allowed to go on without treatment for a week or so, and the patient is "on the go" all the time, they generally suppurate. I rather believe that these gonorrheal buboes are the result of simple irritation, and not caused by the absorption of the pus microbe. In regard to the opening of these enlarged glands, I do not agree with Dr. Palmer or with Dr. Cartledge that a small incision is all that is necessary. My experience is, that much better results can be obtained by making a free incision and removing all the enlarged glands than by simply making a small incision and trusting to peroxide hydrogen injections.

The essay of the evening was read by Dr. E. R. Palmer; subject, The Present Status of Urethral Surgery. (See page 161.)

J. E. HAYS, M. D., *Secretary.*

TETANUS ANTITOXIN IN TETANUS.—Berger (*Sem. Méd.*, November 30th), at a meeting of the Academy of Medicine on November 29th, related the case of a young man, aged twenty-eight, who was wounded on the little finger of the left hand on July 23d. Fifteen days later he began to develop the symptoms of tetanus, which became more and more marked in spite of the administration of chloral, and on August 16th he had the first attack of general tetanic convulsions. This was followed by daily attacks of increased severity. Chloral was pushed to 24 grams a day in conjunction with 0.06 centigram of morphine without avail, and death seemed imminent. The finger was amputated on September 2d, and on that and the following days antitetanic serum, in doses of 40 grams, representing 4 grams of the dry extract (antitoxin) was injected every day, according to the method of Tizzoni and Cattani. Amelioration followed, the tetanic attacks ceased, and the patient left the hospital in the course of a month cured.—*British Medical Journal.*

Abstracts and Selections.

OTOLOGY.—Dr. Læwenberg gives the result of his experience of cases of otitis accompanying influenza observed in Paris during 1891. The affection usually met with was a subacute inflammation of the middle ear, which presented somewhat different phases in different parts of the country. In some places it was accompanied with hemorrhagic myringitis, but in Paris the author only met with a single case of this variety. He did not find it necessary to trephine the mastoid antrum in any of his cases, a fact which he attributes to two reasons: first, in the large proportion of cases mastoid complications were slight; and, second, he first exhausted all mild therapeutic measures, such as large incisions into the drum membrane, inflations of air, and a rigid antiseptic medication before resorting to trepanning.

He particularly alludes to two peculiar classes of cases: first, some cases which were instantly cured by the air douche; and, second, some which were accompanied by a peculiar form of perforation of the drum membrane. In the first class of cases the patients were mostly children who were suddenly seized with pain in one ear—rarely in both. There was at the same time a sensation of heat and a fullness in the ear. Some fever accompanied these symptoms. Examination invariably showed a drum membrane of a dark red color and convex above and behind. A single inflation of air sufficed to remove all the symptoms. Politzer's method was used in children, but the eustachian catheter in adults. In the second class of cases (of which he records two examples) the inflammation rapidly went on to suppuration, and produced a peculiar pear-shaped perforation of the drum membrane, which the author considers pathognomonic. This was accompanied in one case by a prolonged sanguinolent discharge, which resisted all treatment for a while, but which eventually yielded to mild antiseptic injections, inflations of air, insufflation of dry boric acid, and instillation of alcoholic solutions of the latter. . . .

Dr. William Milligan furnishes a contribution to the subject of the etiology and treatment of perforations of Shrapnell's membrane occurring in purulent inflammation of the middle ear. He defines Shrapnell's membrane as that part of the membrana tympani lying above the level of the short process of the malleus. Anatomically it differs from other portions of the tympanic membrane in possessing no middle layer of fibrous tissue, hence it is less-resistant, and has accordingly been named the membrana flaccida. The existence of a minute foramen in this portion of the tympanic membrane has been affirmed by Rivinus, Politzer, Gruber, and others, but denied by Hyrtl and Kessel. The author has found suppuration of the attic, that is, the portion of the tympanum just within Shrapnell's membrane, in five

per cent of the cases of middle-ear suppuration he met with during the last two years. He calls attention to two important points in connection with its etiology. In the first place, it is a curious fact that suppuration of the tympanic attic, accompanied by perforation of Shrapnell's membrane, is hardly ever found as an acute condition. In the second place, it is strange that extensive pathological changes should take place in this portion of the middle ear without a general inflammatory condition of other portions of the tympanic mucous membrane existing at the same time. In almost all the author's cases the disease was secondary to pharyngeal or naso-pharyngeal trouble. In all probability the whole tympanic cavity is affected at first, but later on, owing either to the results of treatment, or to the *vis medicatrix nature*, the inflammation subsides in the lower portions of the middle ear, where free drainage is so much more readily obtained; whereas, on the other hand, pus gets locked up in the folds of mucous membrane in this upper segment, and so gives rise to a chronic inflammatory condition of the mucous membrane, which it is exceedingly difficult to eradicate. Adenoid growths are frequently associated with suppuration in this region. Children seem especially liable to it. Caries of the ossicles is a frequent result. Of the three ossicles, the incus is the one most frequently found diseased.

The treatment of the disease is at times most difficult, and is always tedious. The main guiding principle should be the securing of thorough drainage. The ordinary ear syringe, applied through the external meatus, is not of any great service in dislodging the matter, as the stream of fluid is frequently quite unable to gain entrance through the small perforation. Siegle's pneumatic speculum may be employed with advantage to suck out purulent matter. When the opening is very small it should be enlarged. The author's intra-tympanic syringe is recommended. Instillations of peroxide of hydrogen (two or three drams to an ounce) are of much service in penetrating into regions hardly accessible to any form of syringe. In severe cases, where the ossicles are diseased, resort may be had to scraping the diseased area of bone with fine Volkmann's spoons, or to excision of the diseased ossicle or ossicles.—*W. H. Harsant, Bristol Medico-Chirurgical Journal.*

BILIOUS FEVER, NOT YELLOW FEVER.—Dr. Domingos Freire, whose researches on yellow fever have from time to time attracted much attention and criticism, especially at the hands of Dr. Sternberg, of the United States Army Medical Department, has recently demonstrated the fact that the bilious fever of hot countries is a distinct disease from yellow fever, that the symptoms are entirely different, and that the bacteriological causes are also distinct. As regards symptoms, he finds that in yellow fever there are three distinct periods: (1) a period of hyperpyrexia, which lasts for twenty-four or forty-eight hours; (2) a short, variable period of apyrexia; and (3) a recurrent hyperpyrexia, during which the phenomenon of hemorrhage

and the ataxo-adyamic symptoms appear. The icterus comes on during the second or third period and sometimes even only after death. There are the peculiar look of the face, the watery vomit, which gradually becomes darker or even black, this symptom continuing for a long time, the marked constipation, and, only in the later stages, diarrhea. Yellow fever is contagious, and does not usually recur; there is no enlargement of the spleen except where there has been antecedent malaria. It is entirely intractable to the use of quinine and its salts. The organism associated with its etiology, Dr. Freire thinks, is a micrococcus, the so-called micrococcus xanthogenus. In bilious fever, on the other hand, there is a regular periodic advance, sometimes intermittent, sometimes remittent; in the first case, with marked irregular exacerbations; in the second, with a febrile exacerbation, which generally occurs toward evening or during the night. The yellow coloration generally commences at the beginning of the disease and continues throughout its whole course. The characteristic facies of yellow fever is quite wanting, the vomit matter is yellow or green from the commencement, and gradually diminishes as the disease advances; bile-stained motions are passed during the whole course of the disease; it is only slightly infectious, but the patient is subject to recurrence of the disease; the liver and spleen are hyperemic and congested, and they often undergo fatty degeneration. The implications of these organs, together with the fact that quinine salts have an almost specific action upon the progress of bilious fevers, indicates that this disease is probably of a malarial nature. Dr. Freire was able, moreover, to isolate a bacillus about $\frac{1}{500}$ of a millimeter in length and $\frac{1}{3000}$ of a millimeter in breadth, non-motile, deeply stained by methyl violet, sometimes slightly curved, and usually containing a single spore at its extremity. These, if not identical with, resemble the organisms described by Klebs and Tommasi-Crudeli. When inoculated they are fatal to guinea-pigs, from the bodies of which they may again be separated. It is interesting to note that he was able to obtain these organisms not only from the blood, but also from the urine and from the bile.—*London Lancet*.

ECTOPIC GESTATION.—Pinard (*Ann. de Gynéc.*, August and September, 1892), relates twelve cases of extra-uterine pregnancy in which the fetus died, and operation was performed after the sixth month. Eleven recovered and one died. The operation in the fatal case was performed *in extremis*. In only one case was there any history of previous disease of the genital tract. In all abnormal symptoms appeared before the end of the first month, due to peritonitis and to intestinal and vesical irritation. In most of the cases no decidua was passed. The period is always suppressed in ectopic gestation, and does not reappear until several months after the death of the fetus. The relation of the uterus to the sac is indefinite. In one of Pinard's cases it lay in its normal position. It may be pushed backward or aside. As a rule it is pushed forward. The cyst is nearly always fixed by adhesions, yet it may be perfectly movable. Pinard

declares that he has noticed strong contractions of the wall of the sac, as in a normal gravid uterus. The sac may be inseparably adherent to intestine. It always includes two compartments, one for the fetus and one for the placenta, and they may rupture separately. The fetal compartment may be bilobed and so constricted at certain points as to render the complete extraction of the fetus impossible. Thus in one case Ribemont-Dessaignes was obliged to decapitate, and the head could not be extracted until the nineteenth day after the removal of the body, and three days after the last piece of placenta came away. Even then it had to be crushed with forceps. The fetal sac is undoubtedly in many cases more accessible from the vagina than from the abdomen. Two out of Pinard's twelve cases were "elytrotomies," the remainder being abdominal sections. The surgeon is by no means called upon or justified in removing the sac in all cases. The indication is what the French conveniently call simple exteriorization of the cyst cavity. Rupture of the sac late in pregnancy may not cause either peritonitis or hemorrhage. The intestines may tolerate the presence of a fetus free in the abdominal cavity. These facts seem to prove (in Pinard's opinion) that after the fetus has been three months dead the placenta may safely be removed complete during the operation. Death of the fetus may involve grave acute symptoms, as in Pinard's fatal case, where there was urticaria and suppuration, rupture of the cyst and peritonitis. In conclusion, judicious surgical interference is always called for in the later stages of ectopic gestation. The surgeon must not be too ready to prefer abdominal section to opening of the sac through the vagina.—*British Medical Journal*.

CORROSIVE SUBLIMATE AS A GERMICIDE.—Dr. C. T. McLintock has made some extensive researches upon corrosive sublimate as a germicide. His experiments show that this substance is not a strong germicide, as germs withstand its action for some time. He maintains, however, that though corrosive sublimate is not a good germicide that is no proof that it may not be valuable as a disinfectant. As is well known, of all substances it has the greatest antiseptic power, and, according to Dr. McLintock's theory, a germ treated with sublimate, unless perchance it gets into the blood or is exposed to very exceptional conditions, is powerless to grow, that is to say, it is probable that a spore of subtilis or anthrax treated with sublimate (1 in 1000) and then thrown on the soil or into water will not germinate, owing to the fact that the capsule of sublimate surrounding it is not removed. The former experiments alleged to prove its germicidal power were faulty, inasmuch as in some there was carried over with the disinfected material enough of the sublimate to act as an antiseptic; in others, as those of Abbott, it was not recognized that the sublimate combined with the investment of the germ and prevented any growth, especially in solid media. Again, different cultures have, as pointed out by Esmarch and Gruber, very varying powers of resistance, an all-important

factor in determining the germicidal value of any agent. Corrosive sublimate forms with cellulose, as cloth, filter paper, etc., with silk, with albuminous bodies, with some part of bacteria, probably the envelope, a chemical compound that can not be removed with any amount of washing with water. Thus sublimate when acting on a germ forms a capsule around it that protects the germ for a time from the further action of the sublimate, and in turn forms an impenetrable barrier to the growth of the organism unless removed. This barrier may be removed with salines, and is more rapidly removed in proportion to the renewal of the saline conditions that are fulfilled in the circulating blood. The action of sublimate on bacteria is probably closely analogous to that of alcohol. All experience leads to the belief that absolute alcohol is immediately fatal to protoplasm, and the only way that we can explain the fact that spores may survive in absolute alcohol for weeks is on the assumption that the alcohol somehow changes the envelope of the spore, rendering it impermeable. Dr. McLintock thinks with De Barry that the presence of a gelatinous envelope in many, if not all, bacteria at certain stages of their life history has not received the attention it deserves. This envelope probably serves the organism in protecting it against temperature, dehydration, and chemical agents. Whether the germs contained in solution treated with sublimate, and disposed of as such material usually is, do or do not grow remains to be proved.—*London Lancet*.

DERMATITIS DUE TO OPIUM.—A. J. Lanz, of Moscow (*Meditzinskoï Obozrienïe*, No. 14, 1892), reports an unusual case of idiosyncrasy to opium. A woman, aged twenty-nine, suffering from acute bronchitis, was given eight ordinary doses of Dover's powders (two to be taken daily). About eight hours after the first powder severe rigor, fever, and headache came on, and the whole skin turned quite red. On the third day universal desquamation occurred. When first seen by the author (four days later) the woman looked exceedingly ill, complaining of incessant shivering, thirst, anorexia, headache, sleeplessness, and a feeling of tension all over the integuments. The entire cutaneous surface from head to feet was congested, dry, and covered with epidermic scales of varying size. From the body the epidermis could be detached in large sheets, while from the hands and feet it could be taken off in the shape of gloves and slippers. In four or five days the skin became pale, and the desquamation nearly ceased. The cough being still present, two 5-grain doses of Dover's powders were ordered. About seven hours after the first dose a severe rigor came on, and lasted several hours; and after the second powder the skin again became intensely congested, swollen, hot, and painful, and the patient complained of headache, thirst, fever, etc. Two days later general desquamation again took place. Two 5-drop doses of opium tincture (*Ph. Ross.*) were again given some time afterward, and this was again followed by a similar train of symptoms. The woman was finally discharged well.—*British Medical Journal*.

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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JOHN WESLEY IN MEDICINE.

The editor of the Boston Medical and Surgical Journal has unearthed a book that had great favor with the good people of England and America a century or more ago. Its title is, "Primitive Physick; or an Essay on the Natural Method of Curing most Diseases," by John Wesley, the founder of Methodism. The first edition appeared in 1747, the thirteenth and last bears date 1768. Thus it will be seen that the book was a hit, as most any book would have been by so popular a man as Wesley, and that the multitudes who believed the gospel of Christ, which he preached with so much eloquence and power, by a similar stretch of faith took as truth the unscientific crudities of this dogmatic work.

The book, though liberally quoted from by quack writers on domestic medicine of a half a century ago, is now very scarce. It is certainly one of the curios of medical literature.

We quote in the main the editor's excerpts from the book, with his temperate and wise comments:

Wesley arraigns physicians for making of medicine "an abstruse science quite out of the reach of ordinary men." They have done this "that the bulk of mankind might not pry into the mysteries of the profession." To this end they have abandoned simple for complicated remedies, and have "filled their writings with abundance of technical terms, utterly unintelligible to plain men. . . . They affect to deliver their rules and to

reason upon them in an abstruse and philosophical manner. . . . They represent the critical knowledge of anatomy (and even natural philosophy and astronomy) as necessary to the understanding of the healing art." Those who understand only how to restore the sick to health "are branded with the name of empiricks." They have introduced into practice "abundance of compound medicines, consisting of so many ingredients that it is scarcely possible for common people to know which it was that wrought a cure; abundance of exotics, neither the nature nor names of which their countrymen understood; of chemicals, such as they neither had skill nor fortune nor time to prepare; yea, and of dangerous ones, such as they could not use without hazarding life but by the advice of a physician. . . . And thus both their honor and gain were secured, a vast majority of mankind being utterly cut off from helping either themselves or their neighbors."

Wesley's "Primitive Physick" consists of a "collection of receipts," arranged in alphabetical order. Under the head of "Abortion," we read: "Use daily a decoction of lignum vitæ. . . . Or, in a sanguine habit, let blood." For an ague: "Go into a cold bath just before the cold fit. . . . Or make six middling pills of cobwebs. Take one a little while before the cold fit; two a little before the next fit; the other three, if needed, before the third fit. I never knew this to fail."

This is only a part of the remedies advised. Wesley inveighs against Peruvian bark, which "is very dangerous," and "frequently turns an intermittent fever into a consumption." He enumerates instances of this, one of them being his own case. The cinchona bolus in less than six hours inflamed and ulcerated his lungs, and by this summary process brought him "to the third stage of a true pulmonary consumption," from which he narrowly escaped. He advises all to shun bark and use cobweb pills instead, which "will cure nine cases of intermittent fever out of ten."

Under the head "Bilious Colic" the patient is advised to take a spoonful of sweet oil every hour. This has cured one judged to be at the point of death." Here Wesley is seen to have recommended a remedy which seems even to-day to be in fashion for the same complaint.

One peculiarity of the book is the profusion of remedies prescribed, among which the reader can take his pick, though in many instances those which the author has himself tested and found efficacious are marked "tried," or "I," meaning infallible; thus, under the head "Dropsy," we find twenty or more different remedies. The victims of anasarca or ascites are exhorted to apply green dock leaves to the joints and soles of the feet, to drink nothing but lemonade, to eat a crust of bread every morning fasting ("tried"), to "take as much as lies on a sixpence of laurel leaves every second or third day; it works both ways;" to drink tar-water, to drink sea-water, to abstain from all drink for thirty days, etc.

"To cause an easy delivery," we are told to "peel, slice, and fry a large white onion in two or three spoonfuls of the best oil till it is tender; boil

this with half a glass of water; strain and drink it in the morning, fasting, for two or three weeks before the time of child-birth."

Patients afflicted with "green sickness" are to take "an ounce of quicksilver every morning," or to grind together three ounces of steel filings and two ounces of red sugar candy (dose from a scruple to half a dram every morning).

Wesley discarded all "violent remedies," as antimony, opium, most of the preparations of mercury, and bleeding (generally); and he had great faith in the simple remedies, "especially when conjoined with that medicine of medicines, Prayer."

Though apparently much out of sympathy with most of the physicians of his time, he yet speaks in high praise of Sydenham (then dead many years), of Dr. Dover (Sydenham's pupil), Dr. Cheyne, and Dr. Tessit. He, moreover, urges heads of families when in doubt, and "in uncommon and complicated diseases, or where life is more immediately in danger, to apply without delay to a physician that fears God."

A better instance of the wisdom of the maxim, *Ne sutor ultra crepidam*, than the foregoing could not be found. Wesley was a great man, and when he spoke of matters wherein he was at home the world listened, and seems to be still listening. But when he essays medicine, which was out of his proper line of thought and work, he makes the amusing flounder evident in the foregoing quotations. It is true that medicine a hundred and fifty years ago was by no means the rational and scientific system of the adaptation of hygiene and of drugs to the forestalling and curing of disease which it now is; but after Harvey, Sydenham, and Boerhaave, no man with any sort of scientific training could be excused the inflicting upon humanity of such stuff as the foregoing quotations set forth. "Let the shoemaker stick to his last."

Preachers in all ages have meddled with the healing art, as many of them meddle to-day. But the result has always been that they have simply made themselves ridiculous, to the injury of science and the enlargement of quackery. If the tenets of theology are the result of such loose observation and bad use of facts and phenomena as the preacher always displays when he meddles with medicine, it is no wonder that science and skepticism are to-day almost synonymous terms.

The failure of so great a man as John Wesley ought to admonish his lesser would-be followers to mind their own business in trying to make the world spiritually better, and to leave the problems of therapeutics and public health to those who are fitted by study and work to essay their solution.

Notes and Queries.

CARBONIC OXIDE POISONING.—Voss (*Deut. Med. Woch.*, October 6, 1892,) records the poisoning in the usual way of a family of five persons by carbonic oxide. The elder boy was found dead in his bed, and the younger, aged twelve, was admitted into the hospital in an unconscious condition. His face was pale, the lips livid, and the pupils dilated. There was also nystagmus. Attacks of tonic spasm occurred, affecting chiefly the muscles of the extremities, of the face and of mastication. Thus in a paroxysm the wrist and metacarpo-phalangeal joints were flexed and the interphalangeal joints extended, while the thumbs were strongly adducted. The legs were extended, and there was trismus and facial spasm. Breathing became more difficult, and he died within twenty-four hours. The lungs were edematous, with patches of broncho-pneumonia. There were also signs of intestinal catarrh, with swelling of Peyer's patches. The father and mother presented typical symptoms, but recovered rapidly. Blood from the brother, but not from the patient, presented the characteristic CO spectrum. The author thinks that the degree of poisoning was in reality slight, and that death was due to the tetany. In children the commonest causes of tetany are gastric and intestinal affections, and among the causes in adults dilated stomach (see *Epitome*, March 5, 1892, par. 199,) and extirpation of the thyroid body must be reckoned. Both the boys were subject to attacks of diarrhea since they had enteric fever seven years previously. The author thinks that the intestinal affection had much to do with the tetany in the case here recorded, the carbonic oxide increasing the irritability of the nervous centers. The fatal termination of a slight case of poisoning is thus explained, death being due to the spasm involving the respiratory muscles. The prognosis of tetany occurring in other diseases in children is far from good. Toxic substances, such as ergot, alcohol, chloroform, are mentioned by Frankel-Hochwart as causes of tetany.—*British Medical Journal*.

HYSTERIA IN CHILDREN.—Dr. F. Jolly contributes a paper on this subject to the *Berliner Klinische Wochenschrift*. Hysteria in children may take the form of periodical outbursts of peculiar mental disturbances or may produce local symptoms. Most commonly vague pains are complained of in various parts of the body (particularly in the joints), these pains being frequently accompanied with spastic conditions of the limbs (rarely paralyzes) and anesthetics. Both sides of the body are affected in the great majority of cases although occasionally there may be a monoplegia or hemiplegia. To the above symptoms tremors may be added; these tremors may in some cases be the first thing complained of, especially in cases

where traumatic influences have been at work. Further, spasms may occur in the muscles of speech and respiration (sharp cries, singultus, etc.). The speech may become stammering or confused, or the patient become perfectly dumb for a longer or shorter period, and this may even be accompanied by deafness. In some cases observed by Dr. Jolly "hysterical blindness" occurred. As regards anesthesia of the skin and deeper parts this was usually but slightly marked—diminution of the sense of touch, lessened sensation to pain, and contraction of the field of vision. The hysterical attacks were generally characterized by screaming, crying, and laughing, accompanied by convulsive movements of the extremities. There was commonly some slight loss of consciousness, but as a rule the patient retained some recollection of what had occurred. The treatment which proved most effectual was isolation, dashing cold water over the child, the faradic current, and judicious verbal correction. With regard to the cause of hysteria Dr. Jolly found that there was in most cases a history of a nervous disposition in the parents, this being frequently added to by debilitating diseases and bad feeding, anemia and unfavorable moral surroundings. Education and imitation also exerted powerful influence.—*London Lancet*.

SUPPURATIVE DIAPHRAGMATIC PLEURISY AND CEREBRAL ABSCESS.—Leblond (*Arch. Gén. de Méd.*, November, 1892,) reports a case of basal empyema. The patient, a woman, aged thirty-three, left the hospital practically well three months after incision and drainage. Six weeks later (September 20, 1892,) she returned, complaining of cough and wasting. The sinus had reopened during the past few days. On September 29th she was suddenly seized with vertigo and clonic spasm affecting the left side of the face, but subsequently spreading to the right side. A little later in the day there was a further attack of convulsions. There was much pain in the right side of the head. On the 30th the pain continued, and there was right facial paralysis. On October 2d there were convulsions affecting the left arm and leg, dilated pupils, retracted neck, and slight stupor. On October 3d she was semicomatose. There was paresis on the left side, slight clonic spasms of the right arm, and hyperesthesia of the abdomen and thighs. On the 5th the left pupil was smaller than the right, and she was delirious. There were again convulsions on the left side. There was nausea, but no vomiting. The next day the left hemiplegia was complete and the coma absolute, and she died on the following day. There was a sinuous track, about ten centimeters long, between the lung and diaphragm; otherwise the lung, diaphragm, and liver formed one mass. There were no other remains of the empyema cavity. A few tubercles were present in the right apex. The right hemisphere of the brain was larger than the left. There were two collections of pus: the one central, destroying the right internal capsule and adjacent ganglia, and bursting into the ventricle; the other, older and subcortical, occupied the posterior part of the first and second

frontal convolutions, the ascending frontal and part of the paracentral lobe. The abscesses communicated with each other by a fistulous passage, and the subcortical abscess came very near the surface at one point, where there was a patch of meningitis. The pus contained streptococci. The author refers to a case of abscess of the liver complicated by cerebral abscess. The course of events is easily traced in this case, the first attack of vertigo corresponding to the subcortical lesion. The spasms of the right arm and the facial paralysis on the right side could not, however, be explained by the lesions found. If the abscess could have been recognized at first, trephining would certainly have been indicated, but the author does not seem to be very sanguine about the results.—*British Medical Journal*.

BRACHIAL NEURALGIA DUE TO EXOSTOSIS OF THE FIRST RIB.—Verneuil (*Rev. Gen. de Clin. et de Ther.*, November 30th,) reports the following case: A girl, aged twenty, came under his care at the Pitié Hospital in 1884. Five years previously she had begun to complain of numbness in the left arm; a year later she noticed a small tumor in the supraclavicular region, and soon the pain caused by this tumor extended all over the scapular region and the upper limb. On examination a hard tumor was found springing from the first rib, close to the insertion of the scalenus posticus. The subclavian artery and the branches of the brachial plexus were pushed up and compressed by the growth. The latter was removed, and the pain ceased. Six months later the pain returned, and it was found that the tumor had recurred; it was again removed, and the patient seemed to be permanently cured. More than seven years subsequently, however (in May, 1892), she again presented herself, complaining of renewal of the pain. No bony projection could be felt on the first rib, but the cicatrix was tender to the touch, and the pain radiated over the whole arm, shoulder, and upper part of the thorax. Ricard, who was doing duty for Verneuil at the time, thinking the brachial plexus had become adherent to the cicatrix, completely freed it therefrom; but this operation was not followed by any relief of the pain. Medication of the most varied kind was employed without avail, and Verneuil was on the point of giving up the case as hopeless when it occurred to him to expose the brachial plexus, and to apply a solution of cocaine (20 per cent) to its branches. This measure proved completely successful; the patient on waking up from the anesthesia was entirely free from pain, and has not since suffered from it.—*Ibid*.

UPRIGHT AND SLOPING WRITING.—Mayer, as a result of the study of forty schools in Bavaria with over two thousand pupils, finds that with upright writing fifty-five per cent of the children sat in a good position, whereas with sloping writing only five per cent were found to do so. He finds that the better the position of the pupil the less the letters incline, and that if vertical writing is taught, children sit in a good position with far less trouble.—*Boston Medical and Surgical Journal*.

Special Notices.

THE THERAPEUTICS OF TERRALINE.—Chas. Kelley Gardner, M. D., Huntington, W. Va., writes to the Terraline Co.: After having made a thorough trial of Terraline under a number of varying conditions and over a somewhat extended period of time, I desire now to give to my professional friends some of the conclusions to which I have arrived. I can not recall a single instance in which it has failed to produce all that is claimed for it—therefore, feeling assured that I am giving relief to my suffering patient. Terraline stands without a peer to-day in the treatment of all inflammatory conditions of the respiratory tract. I have especially noticed the good results following its use in the following conditions:

Capillary Bronchitis. In capillary bronchitis, administered in teaspoonful doses, it modifies the cough, increases the expectoration, and generally improves the patient.

Phthisis Pulmonalis. In phthisis pulmonalis, I have always found Terraline superior to cod-liver oil. It does not simply palliate the cough; it allays the pulmonary irritation, improves the digestive and assimilative powers, and overcomes the repugnance to food so often observed in this disease. I invariably prescribe it with creosote as follows:

R. Creosote, ʒ jss;
Terraline, ʒ xij.

M. Sig: One teaspoonful three or four times daily.

This can be modified by prescribing double the amount of Terraline, and administering two teaspoonfuls at a dose.

Chronic Bronchial Catarrh. In chronic bronchial catarrh it has never disappointed me. In fact I have even received the most flattering and most positive results, exceeding often my highest expectations. In the croupy coughs of children and in croup itself it is prescribed with the greatest benefit.

A Reconstructive. Terraline is a reconstructive and tissue builder of great power. Some months ago I prescribed it in a case of general anemia in an excessively chlorotic girl. The improvement was soon marked and progressive. She used the remedy three months, and gained in weight five and one half pounds each month.

Weak Stomachs and Fastidious Patients. As Terraline is so easily digested and is entirely tasteless it can be administered indefinitely to the weakest stomach without creating a repugnance to its use, a most decided and important desideratum. Children and fastidious females take it readily, for, as stated, it is without taste, is odorless, and it does not produce eructations. In conclusion, I would say that in Terraline we have a product of purified petroleum without the disagreeable taste and odor of crude petroleum, and yet with all the medical qualities fully preserved.

THE VALUE OF ARISTOL IN CATARRHAL AFFECTIONS.—During the final days of winter and the early weeks of spring, when catarrhal affections of the respiratory passages are an equal source of worry to physician and patient, Aristol does excellent work. Dr. Porteous writes [Am. Therapist]: "Aristol in post-nasal catarrh and hay-fever has acted well in my hands. After thoroughly douching the nasal and post-nasal passages, also the pharynx, with some antiseptic lotion I apply to all available parts the powder. In no cases have I seen failure." Aristol has been equally successful in catarrhal maladies of the ear, even after the lesion has progressed into the most unsatisfactory morbid conditions. Dr. W. Byrd Scudder writes [Ec. Med. Jour., Jan., 1893]: "In a suppurating middle ear, where most of the membrana tympani has sloughed away, Aristol may be blown in to perfectly coat all unhealthy tissue. I used it in a case of necrosis of the bones of the canal with excellent results." Dr. R. H. Gibbons recommends Aristol [Times and Register, Dec. 10, 1892.] in a great variety of conditions calling for surgical treatment. He adds: "I have resorted to the use of Aristol in the dressing of surfaces in the cavities of the body, those of the ear, the nose, the vagina, and the rectum." His results, he writes, "have been satisfactory to an extreme degree."

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"NEC TENUI PENNĀ."

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Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

THE INCIDENTS AND EXIGENCIES OF THE PHYSICIAN'S LIFE.

The Doctorate Address in the Medical Department of the University of
Louisville, 1893.

BY W. O. ROBERTS, M. D.

Professor of the Principles and Practice of Surgery in the University.

It is a custom with those modern peripatetics, the tramps, to place somewhere about the premises they chance to visit such signs as these: "They keep a dog here," "Don't eat the pie," "Look out for the old man," "You can work the old lady for a dinner," etc., that their fellows who shall follow may be warned to pass on, or encouraged to stop and forage. And on this principle a peripatetic, but of a different school, who has trudged for a quarter of a century along the dusty highways and flower-skirted lanes of professional life should be able to speak out of his experience to you, who are about to take up the same uncertain line of march, words of counsel, warning, and encouragement.

Having secured the coveted right to practice, waste little time if any in looking for an opening. If the prophet had lived in our day he might have questioned the existence of "balm in Gilead," but he never would have asked, "Is there no physician there?" On the hills and in the valleys, on the mountains and in the meadows, on the knobs and in the bottom lands, the irrepressible doctor rides and thrives, and if you find an opening it must be one of your own making. Go forth, young man, and if the ranks be crowded, wedge in, but don't squeal if you get squeezed. In the selection of a locality, however, 't would be wise to choose the fertile meadows and the rich bottom lands, rather than the scrubby oak barrens or the pennyroyal-perfumed hills. In the order of society, the doctor is a consumer rather than a producer, a necessity or a luxury rather than a missionary

or a martyr; and while it may be the duty of some to practice in regions desolate and unproductive, common business sense should send the others into localities where the soil is rich and the people well to do. "Fat pastures make fat calves."

Having decided upon a location, the first thing to do is to get an office in an eligible place, and to begin professional work by keeping religiously your office hours. Never allow any one to suspect you of a practical joke in opening an office and hanging up your shingle. Read your books if the hours drag wearily and the cases come "like angels' visits, few and far between." It may seem to you sometimes that you have mistaken your calling and are pursuing medicine only as an abstraction—but, patients or no patients, be on hand and ready for work at the appointed time. Some one has said, "Keep your office, young man, and it will keep you." The truth of the maxim is attested by every successful practitioner of medicine.

There are young physicians who delude themselves with the notion that they have no use for books after they secure their diplomas. It would be amusing, if it were not sadly prophetic, to note how light a thing some students would make of the long, weary, doubtful journey to professional success. They are like the young man who one day rushed into Landseer's studio and asked most patronizingly, "Are you Sir Edwin Landseer"? "I am," said the great painter. "Well, sir," continued the visitor, "you have been highly recommended as a teacher, and I have come to have you teach me how to paint. We will have to be in a hurry about it, too," he added, "for I have only three hours to spare for the lesson." The artist eyed the stranger with curious wonder. "By the way," said the would-be painter flippantly, "how long did *you* study painting?" "All my life," was the solemn reply, "and I am still studying." Never forget that medicine, besides being in itself a science, is an art based upon collateral sciences, and that no man can bring to the work too full an equipment of knowledge. You will never find an eminent man in medicine or surgery who does not possess a large and well selected library. Be studious in the books of medicine, the book of nature, and in the book of human life, if you would attain to full stature in your chosen calling.

Be particular not to be found loafing around drug stores, groceries, or worse places. Your too constant presence in pharmaceutical establishments will be considered a confession that you have found yourself a drug in the professional market, while your entrances and exits into and out of certain other places will be construed by the public to mean that your taste is for draughts more stimulating and less inspiring than those that flow from the font of Helicon or the Pierian spring. Nothing can do greater prejudice to a young physician's prospects for success than a reputation for idleness and drunkenness.

"All things come round to him who will but wait," says the proverb, and its truth is borne out in the history of nearly every man who has made

his mark in medicine. Few if any of you will be able to say with the young Lord Byron, "One morning I awoke and found myself famous."

A reputation is not built in a day or in a night, like Aladdin's palace, neither does it spring up and reach the clouds by magic, like the famous beanstalk of fairy lore. Such things are found in story books; not outside them. If you expect, as some do, to carry things with a high hand, and to have a rush of business at the start, you are doomed to disappointment. "There is no excellence without hard labor." Nothing worth the having is attained speedily or without trouble, and the doctor who is discouraged because he does not build up a practice in a few months or years is foolishly weak. It is a matter of history that a member of this faculty collected just one dollar during the first six months of his practice, and there are many successful members of the profession whose early experience was equally disheartening.

A young physician may chance at the start to get a case which pays him well and brings him some reputation; but the incident may nevertheless be a serious disadvantage to him. It inflates his pride and overstimulates his hopes for quick success. He expects like cases every day, and, if his practice does not soon become congested with sick millionaires, he is disappointed, loses ambition, and drops out of the profession.

A talent for keeping his mouth shut is essential to the success of every medical man. Taciturnity in our calling is always a strong point. There are many physicians of moderate intelligence and light equipment who, nevertheless, have with their patients and the public a reputation for great erudition, because they are masters of the golden art of silence. Shakespeare had had experience of such when he said he "knew of those who are accounted wise for saying nothing."

The doctor must necessarily be the custodian of individual and family secrets. In school anatomy may or may not have been your strong point; but you need not be an osteologist to discover a "skeleton in the closet" of every family in which you are called to minister. Be careful never to expose this mouldering, grinning, rattling relic of social disintegration to public gaze. Nothing can be in worse taste for a doctor than to pass as the self-constituted advance agent and bill-poster of his patients' ailments and family troubles, and scattering complimentaries by the way that every body may witness the show. The reputation of the gossiping doctor is soon established. He is worse than a leaky gaspipe, or a chimney with inverted draught. He goes around like an unsealed letter or a hawker of superannuated market wares, and when he opens his mouth the results may well be left to Providence.

A doctor with such a reputation will soon find himself with a deal of spare time on his hands, and with a stock of blunders that the friendly undertaker can not cover up. Guard the secrets of the sick-room and of the consulting room most sacredly. Dismiss your patients' ailments, troubles, and afflictions when you leave them, or they leave you, except

so far as you may need to give them scientific meditation, but let nothing induce you to discuss them with curious or prurient inquirers.

A physician of social disposition is tempted often to linger in the sick-room after his proper work is done. This is a venial fault that should be avoided. It is far better, however, to sin thus than to go to the other extreme—rushing in and out of houses like a milk-man, making diagnoses by snap or guess, and prescribing placebos with the easy facility of the noisy street-corner vender of panaceas for every human ill. Let your stay be long enough to enable you to thoroughly examine the patient, and to make a prescription based on scientific principles. If these trifles hold you for a brief time only, you might with profit prolong your stay until you have made such study of the sick man's face and form as will enable you at least to recognize him should you chance to meet him on the street.

And right here it would be well to lift up voice against the habit of some young doctors (and old ones, too, when angling for practice in new places), who drive along the city or village thoroughfares at a rate of speed not demanded by the exigencies of a practice yet in the embryonic state. A jockey in livery upon a pneumatic-tired sulkey, driving Sunol or Nancy Hanks over a kite-shaped track, and straining for the goal with the velocity of a lightning express train, may be an object of public admiration; but a young doctor behind such a "critter" as his judgment of horse-flesh and lightly-loaded purse lead him to select, and seated in such a buggy as the benevolence of the second-hand dealer makes it possible for him to buy, striving to outrace death on a bumpy street, is an anachronic picture at the same time comical and disgusting to the beholder.

"Be not deceived." The public is not gulled by such flimsy shows of business, and ere long the wags will accuse the offender of training to drive a patrol wagon or Buffalo Bill's Wild West stage coach.

If you would be a successful physician you must make a profound study of human nature; see it in full dress and in its shirt sleeves. Some people like a doctor who carries a long face and the solemn dignity of a funeral director—his very presence makes them feel sicker and more consequential than before; others prefer a medical adviser of a cheerful disposition. Be, if you can be, a Hamlet, or a Mercutio, as the case may require, but never so far forget the dignity of your calling as to indulge in boisterous mirth or vulgarities of speech or manner. Never laugh *at* a patient. Things will sometimes happen in the sick-room which are simply side-splitting; but it would be manifest lack of tact on the part of a physician to exhibit the slightest merriment over any thing except a convalescent's jokes. Whenever the feeble sufferer makes a feeble attempt at wit, the doctor's prompt appreciation and ready laugh will do more to further the return of health than tonics or reconstructives. But if merriment be, as a rule, out of place in the sick-room, certainly anger can never be in place. Keep your temper, no matter how provocative the circumstances

may be, for loss of temper is confession of weakness, and puts you at great disadvantage with the sick and the attendants.

There are physicians who, if called once or twice into a family, delude themselves with the notion that they have from thenceforth a first mortgage bond on it. This is a foolish mistake. There are some people who play no favorites, and change their doctors almost as often as they change their collars. They are like the Irishman who, on a certain occasion, was making much noise about Irishmen and their rights: "What is it that you and your countrymen want?" asked a stranger. "We don't know what we want," responded Pat, "and by the powers we're bound to have it." If you have a patient of this sort, and find that he has called in another doctor, do not be weak and undignified enough to comment on it, or to appear to notice it in any way. Rest satisfied with the knowledge that you have done your best in the case, and if called again be sure to go.

Be honest with your patients. If there is any thing the sick person or his family should know, do not fail to tell him or them. If they desire to call any reputable physician in consultation, accede to the request at once, and do not hesitate to make a like demand when you think it necessary.

It is due the physician when called to a case, that he be given absolute control of it. From that moment he is responsible for the welfare of the patient. If now the family or friends interfere and seek to hamper his actions, he will hold such behavior to show that they accord him neither courtesy nor confidence, and in justice to himself and his profession, he will withdraw from the case, and refuse to be held responsible for its outcome.

There are physicians imprudent enough to express opinions of cases they have never seen, or to allow themselves to be questioned about such cases. Nothing could be more injudicious. The best doctor, with the case before him, may make mistakes. Make no statement, even privately, until you have submitted the patient to a thorough examination. Leave the diagnosis of diseases unseen and the prescribing of medicines at long range to the quack who treats patients by letter, or to the enterprising pharmacist who adapts a drug to a distant case, with about the same chance of a hit as a gunner who should fire in the dark, or of a fit as a tailor who should make a coat for an unseen and unmeasured man. It is also prudent not to be betrayed into saying any thing in criticism of another doctor's work. There are many people who will immediately declare that your remarks are inspired by jealousy, and reckoning on the principle involved in the construction of the boomerang, you may expect your opinions to recoil upon you and not to do execution upon the physician whose ability you have called in question.

Be on your guard against airing your views in cases of malpractice brought against brother physicians. In most instances there are no grounds for the action, and by making yourselves conspicuous by your remarks, you belittle both yourself and your calling.

It is best never to pay unnecessary calls. People do not appreciate a physician's visit when there is no need for it, and will fancy he comes to the house merely for the purpose of running up the bill.

If you are called in to see another physician's patient, be careful that you do or say nothing that may look like a design or a desire on your part to steal the case or the family. Make your visit, do exactly what you think ought to be done, and go.

Many a doctor rides a hobby before he has made money enough to keep a horse. He introduces it in the sick-room, the lecture-room (if he be a teacher), on the street, and in social and domestic life. It wearies, if it does not drive crazy everybody who has the misfortune to know its author and promulgator. "Little Annie Rooney" pales before it, and "Ta-ra-ra-boom-de-ay" can not long maintain a successful rivalry. Hobbies, if not as thick as autumnal leaves in Vallambrosa, are at least as plentiful as colonels in Kentucky. Hobbies are a nuisance, and no more tolerable than puns in conversation or mosquitoes in harvest time. Neither is it wise to allow one's self to be carried away with enthusiasm over new therapeutic fads, such as the Brown-Sequard Elixir, the Koch Consumption Cure, and some more recent supposed discoveries. It is both wise and just to investigate these things that one may see what is in them, but the physician who bears the remotest relationship to King Solomon will not go around eulogizing them as life preservers until he has put them to searching tests.

Another important item in the career of the young physician, is the judicious advertisement of himself. The Code of Ethics very properly puts its ban upon such doctors as take the field with tradesmen and proclaim through the columns of the secular papers the excellency of their methods and the number of their cures. And it would be well for rational medicine, if the doctor who is so frequently interviewed by the reporter as to the sanitary state of the town, the probability of coming epidemics, etc., and those who court cheap notoriety by getting their names mentioned in connection with accident cases and family tragedies or scandals, could be debarred from fellowship with those who stand before the public upon unvaunted merit. But there is always at least one medium through which the physician may properly court notice, and that is the leading medical journals of the day. Keep notes of your cases and report them in the journals. Don't imagine because you may be located in some out of the way place that your articles will pass unnoticed. If there is anything meritorious in what you write, it will be sure to attract attention, and that quickly. "A prophet is not without honor, save in his own country." Our profession abounds in instances of the truth of this much quoted proverb. Americans travel more than any other people. They are constantly going from place to place. Should some one from your neighborhood visit a distant town, and there learn that you had written a fine paper which the journal of that place had published, he would return with praises of your name and comments on your fame, to the enlargement of your business, your usefulness, and happiness.

The physician whose heart is in his work will not be sordid enough to do every thing with an eye to business, nor will he allow either politics or religion to influence him in the discharge of his duty.

A school-boy, upon being asked why a man could not have two wives at one time, answered, "because no man can serve two masters." This comes home with peculiar force to the physician who itches for political preferment. He should devote himself heart and soul to his profession, and seek no office except in the direct line of his business. If he be popular enough to secure a municipal, county, or State office, he should never allow its exactions to interfere with his medical work. The moment he discovers it so doing he will be a wise man, nay, more, a conscientious man, if he give the office up at once.

It is the duty of every physician to do some charity work. A doctor should never refuse to attend the poor. Bread cast upon the waters here will be found after many days. Human diseases and human nature are the same, whether met with in the palaces of the rich or in the hovels of the poor. By ministering to the needy the young physician secures a fund of valuable experience for future use, while often, through the influence of the impecunious, he is called to see patients who are able to pay for his services. But, better than all, he cultivates among the lowly suffering ones that kindness of heart and gentleness of manner, without which he can never successfully perform the offices of medicine.

You can not have urged upon you too strongly, gentlemen, the necessity of keeping accurate accounts. No matter how little you may have to put down, put it down, and thereby lay the foundation of methodical habits. Years may elapse before a patient is in a position to pay what he owes; and, if you have failed to make record of the debt, neither he nor you will be able to determine the amount. Send in your bills regularly every month, and not every six months, as many do. A patient is more apt to pay a small bill covering a brief space than a large one that has become cumulative by time.

Be careful never to commit the injustice of making the rich pay for the poor. Physicians in every locality have regular scales of prices, and you should adhere strictly to the one that touches you. Charge all as near the fixed rate as possible, and the public will respect you for firmness in refusing to be extortionate because the patient has money.

Physicians with families make a fatal mistake if they be lax upon the business side of their profession.

Many a man with a big practice living neglects this important precaution, and dying leaves his family in poverty. Some physicians, in the wild effort to get rich in a hurry, are tempted to speculate; others, through ignorance of business matters, make foolish investments, or do their families gross injustice by failing to keep a record of their work. There are instances of this sort around us everywhere, which always point a moral and too often adorn a pathetic tale.

To neglect to keep accounts is shiftless laziness. To waste one's means in wild speculation or foolish investments is weakness. To fail to make hay while the sun shines and to grow old without a competency, or die leaving one's family unprovided for, is criminal.

It is euphonious, when such a doctor dies, to talk of his generosity and kindness of heart, and to cite the fact that in giving his time and money to the poor and suffering he left his own family without means; this, indeed, sounds well, but he would have shown himself more worthy of praise and of his family if he had protected their interests, and had departed this life after the manner of that model man of whom the poet sang:

"His debts were all settled,
His wife he adored,
He died like a Christian,
And fully insured."

I trust, gentlemen, that this homespun discourse has not been wasted upon your "too diligent ears." The pursuit of medicine is neither a series of steps up Parnassus, nor a highway to the stars, but a simple pathway upon the uneven surface of common-place every-day life. You should walk this way, not as tramps striving to get something for nothing, but as ministers to human need, earning by good work the wages you receive. Do not suffer yourselves to be misled or deluded by rose-colored anticipations; but forget not that the rewards of duty done are full and beatific compensation to him who in "life's late afternoon" recalls the incidents of a well-spent life. The doctor may not soar into the empyrean with the poet, or scale the lofty peaks of thought with the philosopher, and it is rarely his to attain riches or immortality of fame, but "when the sunset gates unbar" he may, if he have been faithful, stand crowned with ineffable glory as one who loved and served his fellow-man along the sacred and oft-times painful line of duty.

And now, on behalf of the Faculty, I wish you Godspeed and good-bye. To each and every one of you we wish happiness and success through usefulness; and you may rest assured that in future nothing will afford us greater pleasure than to know that you have done credit to your instructors and reflected honor upon your ALMA MATER, THE UNIVERSITY OF LOUISVILLE.

CARDIAC STIMULATION IN PNEUMONIA.*

BY JOHN A. LARRABEE, M. D.

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Pneumonia has probably been the subject of more medical literature than any other disease. When I graduated in medicine I am quite certain that of thirty-five theses required of candidates for graduation pneumonia constituted about twenty-five. I well remember the compliment paid me by the faculty because I had chosen some other sub-

*Read before the Louisville Medico-Chirurgical Society, February 3, 1893. For discussion see p. 215.

ject. I wrote my thesis for graduation on the subject, "Hospital Gangrene," and I have many times thought what a relief it must have been to that dignified body, most of whom are numbered with the angelic doctors, to have a change of subject. I may add with pardonable pride that my thesis was made the subject of a special mention.

Those puerile compositions were a tolerably fair reflection of the medical teachings of those days, in which idiopathic inflammation was an acceptable term when illustrated by the stages "*Calor*," "*Dolor*," "*Rubor*," et "*Tumor*." It is also true that there is no disease that more clearly marks the progress made in scientific medicine for the last twenty-five years than this same trite subject, pneumonia; the auscultatory signs—the percussion note, the transmitted resonance, the hepatization, and the stage of resolution were necessary to the elucidation of the phenomena supposed to be produced by a "bad cold." Cheesy deposits, the unabsorbed products of inflammation, were but different stages in the development of tubercle and the cause of the rapid consumption.

How little did we then dream that behind all this patient pathological study, in which we have all craned our necks in the "dead house," that, underneath all this crude tubercle and cheesy deposit, there existed a wonderful world teeming with microscopic life, the light of which should make plain the darkness of that pathology.

Before the wonderful discoveries of Friedlander I taught the crisis of pneumonia was to me a most unaccountable phenomena, in that, without any visible improvement in the consolidated lung, we should have as sudden an assurance of recovery as we had of its invasion. The discovery of the pneumococcus and its pneumotoxin, as the indisputable cause of the disease, and the anti-pneumotoxin, which produces the cure, are stepping-stones upon the boundary of a great natural law.

Those of us who may be permitted to live another decade will see the benefits arising from this discovery, and will be able to arrest the progress of acute infectious diseases by injecting the products of the disease taken from convalescents.

The two grand divisions of pneumonia, which differ none the less widely in etiology than in the mode of termination, will always be taught. The catarrhal form, which, after all, is only an ultimate bronchitis, the type of which is seen in infancy, and as a complication in many of the exanthemata, will not enter into this discussion. It will be understood, therefore, that whatever may be said concerning cardiac stimulation concerns the so-called croupous pneumonia only.

In all this time, regardless of the change of views as to etiology and pathology, men, women, and children have been dying from pneumonia in no less numbers. In all this time the mode of the approach of death has remained the same under any and all treatment, coming through the right heart, a distended right ventricle, a stasis in the pulmonary circulation, and a corresponding emptiness of the arterial current.

It may be truly said that therapeutics follows the advance of medicine just as the coal cart follows the engine, always a reasonable distance behind. Just here I ask your indulgence for a moment while I quote some statistics from the most excellent paper of Dr. J. T. Jelks, of Hot Springs, Ark., who also quotes them from Dr. Townsend Cole-ridge and Dr. Wells' report of "Mortality of Pneumonic Fever." These statistics are entitled to our consideration on account of the care with which they have been collected, and from the acknowledged truthfulness of the author. From the first of these reports it appears that 1,000 cases of pneumonia were treated in the Massachusetts General Hospital between the years 1822 and 1890 inclusive. The average mortality was 25 per cent; from 1822 to 1832 the mortality was only 10 per cent. In the latter report the number of cases tabulated was 223,000, and these statistics include the various hospitals of America and Europe, and embrace the time between 1880 and 1890. The average mortality was 18.1 per cent.

Now in the first period of this time it can not be doubted that the treatment was heroic in the fullest sense of that term as it applies to blood-letting, calomel, and tartar emetic, as this treatment marked the first half of the 19th century. Now to make another division of the same report, the mortality in the last ten years has been 28 per cent, and this must have included many cases treated upon the expectant plan advocated by Dr. James Hughes Bennett. How, then, are we to harmonize the results obtained under a treatment long since condemned by common consent of the profession with the results of the treatment of to-day under the broad light of modern pathology; in other words, the 10 per cent mortality in the decade between 1822 and 1832 with the 28 per cent mortality between 1880 and 1890. Were those Sangrado bleedings and those terribly depressing agents less active upon a stronger population, or did they, in spite of the evils which they could not fail to produce, strike at some underlying principle in therapeutics which we, with all our modern accomplishments, fail to recognize? I am disposed to the latter conclusion. Notwithstanding they come to

us like a sound from the ringing rock of past ages, there is to-day much truth in the statement that blood-letting is indicated in pneumonia. The period for its employment is at the time when the right heart is so overdistended and is about to cease the performance of its function. More blood is coming into the right auricle than can be forced through the obstructed lung, and the ventricle is fagged out in the futile attempt to fill the left heart. The right ventricle is so distended at this time that the apex beat is completely removed from its original site in the interspace between the fifth and sixth ribs, and the ear detects a dull, muffled sound, and percussion reveals an increased area of dullness. All this occurs at a time when the ptomaines from the vegetable pneumococcus are being absorbed into the circulation and before the anti-pneumococcus has been formed in the albumen of the blood. Experiments in vivisection have demonstrated that a heart brought to a standstill in such a diastole may be revived by aspiration of the right ventricle.

The question may then be properly asked, where does the application of cardiac stimulation come in this condition? Is it philosophical to attempt relief by a *vis-a-tergo*, or is it more rational to attempt relief by a *vis-a-fronte*? Are these the indications for the employment of digitalis? It may be a good plan to goad the tired ox that has fallen in the furrow if you want a little more work, but you will have a little less ox. It may be good therapeutics to stimulate a diseased kidney with irritant diuretics if you want just a little more urine and a little less patient; and it may be good practice to give digitalis to a fagged out heart in the stage of hepatization in croupous pneumonia, but I doubt it. Digitalis stimulates a weak heart by contracting the arteries and arterioles, throwing the blood back upon the heart itself, and where there is no pulmonary obstruction the action is prompt and efficient, but the very condition which is killing the patient in pneumonia would be rendered still more dangerous by such an agent. It has been found that even ligation of the lower extremities, just sufficient to prevent the return of venous blood, is followed by relief to the heart. The sense of relief felt by the patient upon the application of a hot flaxseed poultice is in a large measure due to the dilatation of the blood-vessels of the chest walls. Pediluvia would prove also of great service were it not for the ever-present danger of assuming the erect position. Alcohol will prove a far better cardiac stimulant in pneumonia by reason of its power to dilate the capillaries, thereby retaining more blood in the skin, while

at the same time it may have some value as a respiratory food. Nitro-glycerine and the nitrites may be expected to rescue a heart after the manner of aspiration, and theoretically would prove to be cardiac stimulants in the condition under consideration. I understand also that they have been of practical benefit. Cupping, either with dry or wet cups over the region of the inflamed lung, has also been productive of relief. Very warm baths give almost immediate relief, but are difficult of administration to adults. They are available in childhood.

It would be remembered that at one time veratrum viride and aconite superseded blood-letting. These agents, long considered identical in action, have nothing in common. The former does not weaken the muscular power of the heart, and may have a place as a cardiac stimulant in pneumonia, while the latter is a highly dangerous drug, capable, even in moderate doses, of paralyzing the centers of Stechenow in the heart. Strophanthus is a far more effectual and safer remedy in the condition under consideration than digitalis. Strophanthus acts upon the ganglionic motor centers in the heart, leaving the arterial tension alone. Caffein is a cardiac stimulant by no means to be despised in pneumonia. The value of a cup of strong tea or coffee has been long recognized in domestic practice. Very small doses of strychnine may also be of advantage.

LOUISVILLE.

ALEXANDER'S OPERATION MODIFIED.—Chalot (*Nouv. Arch. d' Obstét. et de Gynec.*, October,) shortens the round ligaments in a more complete manner than has hitherto been practiced. The inguinal canal is laid almost completely open, so that without difficulty the entire thickness of the round ligament is detected even in the fattest women. Each ligament is dissected deeply up to and beyond the internal ring, even into the peritoneal cavity. The uterus is not held in its reduced or normal position by an assistant, but reduction is performed by firm traction on the two round ligaments. Each ligament is fixed by suture along the whole of its course in the inguinal canal. No pessary is applied after the operation. Chalot has successfully operated in six cases of painful reducible retroflexion. In the earliest case, performed fourteen months before publication, the uterus remained in its normal position. Chalot maintains that his operation is certain of its aim, and more complete than its prototype established by Alexander. Owing to more thorough exposure of the parts it is simpler and easier.—*British Medical Journal*.

Reports of Societies.

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, February 3, 1893, Dr. F. C. Simpson, President, in the chair.

Dr. A. M. Cartledge: I will just briefly run over the history of a case of extra-uterine pregnancy before showing this specimen. Some three weeks ago I saw a lady, thirty-six or thirty-seven years of age, who was suffering with severe pain coming on suddenly in the right side of the chest, which proved to be an ordinary pleuritic attack, very well marked at first, and subsequently followed by a slight effusion. After a week or so she about recovered from the attack of pleurisy, and was about the house and getting along fairly well, so well that I had not seen her for four days. I was then called to see her, fourteen days ago, complaining of excessive pain in the right side, referred particularly to the region of the appendix. This pain was described as being very intense, having existed all night. I saw her in the morning. She displayed a well-defined tenderness right over the McBurney spot, midway between the umbilicus and the anterior spine of the ileum. I believed that I had a case of appendicitis, but temporized for the time being. Her temperature at that time was 101° , pulse about 100. I saw her again in the afternoon, when she expressed herself as being much easier. This state of affairs continued for two or three days. About the fourth day I detected a slight lump in the right side, over the region of the appendix, about the size of a duck's egg, which was very tender, but there were no evidences of general peritonitis. Pulse now about 120° , temperature 102 . I advised operation, supposing that it was a case of appendicitis; this was refused.

The case went on in this way from day to day, enlargement in the right side increasing in size all the time. I thought I could detect a well-marked fluctuation in this tumor. It was very tense, and was typically in the appendicular region, reaching up above the McBurney point, and, taking every thing into consideration, it was about as clear a case of appendicitis as I have ever seen. Last Tuesday the patient complained of pain right about the median line, just above the bladder; tumor in the right side practically unchanged. I was becoming very

uneasy about the case, and urging operation. Wednesday morning, pulse about 112, temperature 100.5°. I will state though that she complained about a week ago of some little shivering sensations. I told her that she must either consent to an operation or consult another physician, as she was certainly growing no better. She consented to the operation, which was performed last Wednesday. Believing that I had an abscess around the appendix, I made the usual incision over that organ, dissecting down carefully until I reached the sac. Then with a small incision about an inch in length, covering the sac proper, I found there were no peritoneal adhesions in front, because I could see some fresh peritoneum; in fact, the abdomen was already open. It was my first intention to expose the sac, wash out the cavity thoroughly, and remove the appendix, which was supposed to be diseased. I then broke the very superficial adhesions in front, passed my hand around and located this tumor, about the size of an orange. I found the adhesions quite extensive, especially to the colon. I now commenced separating the adhesions leading down to what I supposed was the appendix, and in lifting up the intestines was very much surprised to find the tumor easily freed from its superior attachments. I packed gauze around the intestines to get them out of the way thoroughly; I then drew the tumor up into the wound and found it necessary to enlarge the incision in a backward direction. In removing the tumor the sac was ruptured, and was found to contain probably a pint of fluid. When this fluid ran out of the sac, as the woman was lying on her side, something dropped, which led me to pick it up and lay it aside. The sac was now discovered to be the right tube and ovary, which were tied off and removed. The cavity was thoroughly cleansed, and the patient put to bed in a very fair condition.

An examination of this specimen proves it to be very unique indeed, as one of extra-uterine pregnancy occurring about as near the ovary as we will ever see; a condition that is denied, as you are all very well aware, by some very eminent authorities, among them Tait, claiming that all cases of extra-uterine pregnancy are tubular in character. I believe this is a typical case of impregnation of the ovum just as it was being released by the ovary, the artificial uterus being the ovary itself. The tube is entirely intact. I will state that there is no history of recent cessation of menstruation, and none of the usual symptoms of extra-uterine pregnancy. How old it is I do not know.

What I want to call especial attention to, is the fact that the arti-

ficial uterus is the widely separated ovary or ovarian tissue. This patient has had one child, about fourteen years ago. She has since made an uneventful recovery.

DISCUSSION.

Dr. W. O. Roberts: I think a microscopical examination ought to be made of the specimen, to determine to a certainty whether or not it is a case of extra-uterine pregnancy.

Dr. J. G. Cecil: I would not be able to give a positive opinion in regard to this case from the history given. Certainly the ovary is present in the specimen, and the fimbriated extremity presents a cavity which may be the cavity of an abscess, a hemato-salpinx, or it may be an extra-uterine pregnancy. I think it could be very easily demonstrated by a microscopical examination. If it be extra-uterine pregnancy, it would show evidences of fetal structure. However, I do not think it is by any means conclusively demonstrated thus far.

Dr. Cartledge: It did not occur to me that there would be any difficulty in recognizing the nature of this pathological specimen macroscopically, or I would have had it microscopically examined before presenting it. This, however, will be done later.

In the first place, I detailed the history very carefully, and I would like to ask the surgeons who may be inclined to the belief that it is a case of pyosalpinx, if they ever saw pyosalpinx so large as this without pelvic peritoneal adhesions. I do not see what could possibly be suggested except extra-uterine pregnancy. Even if microscopical examination reveals no evidence of a fetus, I shall still think it extra-uterine pregnancy, and that the fetus has entirely passed away, has become digested.

Dr. A. M. Vance: Do I understand Dr. Cartledge that there was never a case of pyosalpinx without adhesions?

Dr. Cartledge: I have never seen a pyosalpinx one half this large without peritoneal adhesions, and do not believe it ever occurs.

[A subsequent microscopical examination by Dr. Vissman of the body found in the sac reveals clearly fetal and placental structures.]

The essay was read by John A. Larrabee, M.D.; subject, Cardiac Stimulation in Pneumonia. [See p. 208.]

DISCUSSION.

Dr. Wm. Bailey: I am inclined to believe that there is something in what Dr. Larrabee has brought before us in his paper. However, it is not entirely new. I remember the same question came up in the Sec-

tion on Medicine in Detroit last year. It was advised that we use nitroglycerine instead of digitalis for dilating the capillaries. Others claimed that nitroglycerine gave no better satisfaction than digitalis. However, I do believe that in very many of these cases digitalis is advisable when the conditions indicate that the heart is overworked, and it becomes necessary to contract the arterioles; of course I can conceive how digitalis in other cases would not give relief. I should hesitate a long time before discarding a remedy so valuable as digitalis, and resorting to other stimulants which do not contract the arterioles to the same extent.

Dr. A. M. Cartledge: What would you consider an indication in pneumonia for the administration of digitalis or any other stimulant, or how long would you wait?

Dr. Bailey: I believe the principal thing in the treatment of croupous pneumonia is the management of the heart. I would put the patient in the best possible condition, and assist the heart by medicine, if necessary; and when it became evident that the right heart was being overdistended, then I think the introduction of a cardiac stimulant imperatively demanded. I am not quite ready to admit that I can always tell when the right heart is overdistended by auscultation, percussion, change of pulse, etc., because these phenomena may not be very manifest. Certainly I think in these cases the higher the fever the greater the danger to the heart, just as it is in every disease in which high temperature is a factor.

Dr. D. T. Smith: The conclusions, as stated by Dr. Larrabee, in regard to the use of digitalis are those which I have reached some time since, and I heartily indorse all he has said. My experience with this drug in pneumonia has been such that I feel justified in saying that it should be used with extreme caution. Concerning the microbic origin of pneumonia, notwithstanding the recent so-called discoveries and theories in this direction, I am still in extreme doubt. This is not directly in line with the subject under discussion. However, I will state in regard to the epidemic nature of pneumonia, when we see that a little change in the atmosphere from British Columbia to the Gulf Coast will spread pneumonia throughout this whole territory within a time, a limit of two or three days, it would seem that there is something beyond the microbe to cause it.

As to the treatment of cardiac failure in pneumonia, of course the condition of the patient as to age, strength, etc., and the extent of the

involvement, indicate the danger. The portion of lung involved we have nothing to do with, other than to endeavor to secure its protection until the forces of the system can bring about a resolution. I can hardly see the necessity for commencing cardiac stimulation at the beginning of an attack, as is claimed by some authorities. This treatment should be instituted only when there is evidence of failure of the heart to properly perform its function. I do not mean the fatal failure, but when the heart fails to send the blood through the affected lung in the proper quantities to effect adequate oxygenation.

I have been in the habit of using digitalis, but always in small doses. I think our aim should be in these cases to improve the general system of the patient, and as far as possible give medicines that will not disturb the digestion or appetite. A year ago I was called in consultation to see a case of grip and pneumonia in a very aged patient. I hardly thought it was a case where digitalis should be given, yet as my consultants advised its administration I felt no harm would be done. One twelfth of a grain of digitalin was given in twenty-four hours, one sixtieth of a grain every four hours. Very unfavorable symptoms developed, lasting for several days. I have no doubt that owing to the condition of the patient at the time this was too large a dose. I believe alcohol is very valuable as a cardiac stimulant in these cases. I would also advise the use of strophanthin, which acts without contracting the arterioles. In the use of a drug which contracts the arterioles it seems to me that the heart is given a greater amount of work to perform, hence I fail to see the advantage of such treatment. Strychnine is also of service in these cases, as it acts as a steady stimulant on the heart's action, acts upon the stomach in increasing the power of digestion and desire for food. I want to emphasize the fact that I believe digitalis should be used with extreme caution.

Dr. J. A. Larrabee: In closing I would like to avail myself of the opportunity of thanking the Fellows of the Society for their consideration of the subject presented. My attention was brought to this subject very pointedly in this way: I have seen numbers of fatal cases of pneumonia in which digitalis was being administered, and was impressed with the fact that we were not getting the effect that digitalis ought to produce. Instead of lessening the pulse, it became more violent under its administration; instead of increasing the force of the heart's action and having generally a good effect, the opposite was the result. Then in looking up the statistics, as stated in the paper, there is something in this point, that

blood-letting, although producing so many results of evil, as we grant it does, yet it strikes evidently the all-important point in the treatment of pneumonia, as shown by the statistics between 1822 and 1832, the mortality being but ten per cent. I became convinced, as Dr. Smith has said, at the bedside, that digitalis did not and will not produce the good effects claimed for it. It is like introducing ergot into a full bladder to expel the urine, instead of using a catheter to draw it out.

The point made by Dr. Bailey is one of considerable importance, especially in croupous pneumonia, that the greater the pulse, and the higher the temperature, the greater the danger is.

J. E. HAYS, M.D., *Secretary.*

THE LOUISVILLE SURGICAL SOCIETY.*

Stated Meeting, January 9, 1893, Dr. A. M. Cartledge, President, in the chair.

Dr. A. M. Vance: This gentleman is forty-two years of age. Sometime in September last he was taken with constipation. He was attended by Dr. H. M. Goodman. About the tenth day after the attack I was called in consultation. During the first ten days of his illness there had been considerable pain, referable particularly to the appendicular region; but when I saw him there was no severe pain, not much tenderness, not much tumor. However, there was some swelling in the ileo-cecal space, evidence of pain on deep pressure, and some tumefaction. Forty-eight hours afterward I opened a large abscess in the right loin, making an incision about the middle of the ileo-costal space. The man was then in delirium, it being almost impossible to hold him in bed. Quite a quantity of very offensive pus was evacuated, together with considerable fecal matter; also this appendix vermiformis, which had separated spontaneously, and a number of enteroliths which were not preserved. These enteroliths were very hard, about the size of a lead pencil, and two inches in length. Evidently when Dr. Goodman first saw this case there was a circumscribed abscess around the appendix, which afterward ruptured into the post-peritoneal space. The patient made an uninterrupted recovery, and is here this evening to show the result of the operation.

This case illustrates a point which has been often questioned, viz., that the appendix does sometimes slough off into the post-peritoneal

*Stenographically reported by C. C. Mapes, Louisville.

space. After the operation, and before the wound closed, a good deal of material came away looking like coffee grounds, and also a piece of egg-shell about half the size of your finger nail. The quantity of pus removed was about one quart and a half.

No. 2. This patient is a man whom you all know, and who had a history, prior to my seeing him, of two attacks of what was supposed to be appendicitis. Dr. John Barbour was the attending physician in each attack. I saw him first, early in the summer, just as he was getting over an attack which passed away after the usual medicinal treatment. I saw him again early in October in a second attack, and at that time, the family having repeated the medication used in the former attack, he was convalescent. I told him if he had another attack to advise me and I would operate upon him. I was called suddenly about a week after this, the message being that this patient had fallen on the street near the Courier-Journal building, was in great pain, and unable to walk. I sent my assistant, Dr. Rice, immediately to the scene. He found the man suffering with severe pain in the right iliac fossa and apparently unable to move. He gave him one half grain of morphine hypodermically, telephoned for a conveyance, and had the patient taken to his home. I went out at once, and when I arrived found the man in convulsions with pain, paroxysmal in character, and being held in bed by Dr. Rice and two or three other men. We administered chloroform and made the ordinary incision over the appendix. It was with considerable difficulty that we located the appendix. It was very far back and high up, and when first discovered I thought it was very large.

Upon further examination it was found that the appendix was enveloped in a coil of omentum or fat, which accounted for its apparent increased size. The appendix was about the size of a lead pencil, and seemed to have nothing in it, particularly from the appearance outside. I excised it, however, and you will see here the remains of it. I have on the slide of the microscope a section, the diseased condition of which can be easily determined by macroscopical examination. After dressing the case I opened the lower part of the appendix, and ten to twenty drops of muco-purulent material came out. No drainage was used in this case. The man has recovered, and has had no further trouble. Operation done October 4th.

No. 3. Here is a little boy I saw, I think, in August. He had then been sick five weeks, and had been losing ground all the time, with

evidence of a large abscess in the right iliac fossa. Dr. Hays had attended him, and upon leaving the city for a brief period directed that a surgeon be called. I believed from the history of the case that it was the result of an appendicular abscess, and took the patient to the Children's Hospital and opened it, evacuating a large amount of pus from the post-peritoneal space. The thigh was flexed almost at right angles, and could not be extended, but came down gradually after the abscess had subsided. He has now become perfectly well. In the operation I did not look for the appendix, as it was post-peritoneal. The peritoneal cavity was walled off in this case.

I have three other appendices, with sections on the slide of the microscope, which I would like to have you to examine. The first is a normal one; second is an appendix removed from a patient of Dr. McDermott. The history was that the patient was perfectly well on Sunday at dinner; Sunday night he was taken sick with abdominal pains; all day Monday he vomited and continued sick with abdominal symptoms; Tuesday he had very high fever, abdomen tympanitic. On Wednesday night at eight o'clock I was called, and told him I thought he had a case of appendicitis, and that perforation had taken place, as the man had general peritonitis, and advised early operation. This was consented to after several hours' delay. I made the ordinary incision, and turned out a gangrenous appendix which had ruptured, the abdominal cavity being filled with pus and fecal matter. The cavity was thoroughly irrigated, and the patient put to bed with considerable shock. He seemed to rally, however. The next morning he appeared to be doing well; but after that time he sank, and died of septic infection in twenty hours. I believe if this patient had been operated upon sooner he would have been saved, showing the importance of formulating some rules in order to determine just when operative procedure is called for.

Here is another specimen, removed on September 16th, Dr. Dugan assisting. The appendix had just gotten to the softening point; evidently would have perforated in a few hours more. There was a hood of omentum formed over it, making a perfect covering. This man had been sick only twenty-four hours; has made a perfect recovery.

Dr. W. O. Roberts: The first case reported by Dr. Vance is exceedingly interesting. There was considerable material, not only pus, but fecal matter in the cavity of the abscess, and after evacuation of the abscess the fecal matter ceased to escape entirely. We meet with cases

of this character sometimes in which fecal matter escapes for awhile after operation, then stops. In this case it seems to have ceased at once. It is a little unusual with sloughing of the appendix to get such prompt union as to prevent the escape of fecal matter.

The second case is also interesting. It seems that every attack the patient had came on very suddenly; the narrator did not state just how long they lasted. I saw the appendix soon after it was removed, and, as Dr. Vance says, there was a good deal of fat about it. The only evidence of trouble that we could detect at the time was that the appendix seemed to be thickened. The doctor says that under the microscope, however, it shows unmistakable evidences of inflammation. The man has now gone longer than he did before operation without a similar attack, and I hope he will be permanently relieved.

Dr. H. H. Grant: There is one point I would call attention to. Dr. Vance reports two cases in which the abscesses are found outside the peritoneal cavity, though the focus in each instance was clearly within the cavity. These illustrations strengthen the position of later pathologists, that these abscesses always have an intra-peritoneal origin, no matter where the products of the inflammation are found. The question of the pathology of these deposits is the key to the treatment, hence every light on the subject is to be made use of in the appropriate application. The subject of appendicitis is too much contested to admit of settlement in these discussions, and though it were easy to talk at length of it, it is unlikely we can arrive at any definite conclusion.

Dr. W. C. Dugan: The subject of appendicitis, of course, is one of great interest to all. The first case reported by Dr. Vance is one of especial interest to me, and I have come to the conclusion now that most all of these cases die from suppurative peritonitis. Very often gray patches are observed over the cecum, colon, and intestines, and I believe that these cases are almost uniformly fatal. I remember two cases I have operated upon presenting this condition, where the patients seemed to bear the operation very well, but afterward died of septic paresis, seeming to have paralysis of the vaso-motor system.

The second case is also very interesting, showing so little evidence of disease, and yet the symptoms were very much aggravated. I remember a case I recently sent to the Norton Infirmary from the City Hospital, a patient who had been treated in Chicago, then stopped here on the way south, and had several attacks of abdominal trouble closely fol-

lowing each other at the City Hospital. At the Norton Infirmary I opened the abdomen, and, as expected, found the appendix filled with pus, but to my very great surprise the cavity was found to be entirely free from any inflammatory process, simply a cold abscess. The patient was very promptly relieved by the operation, leaving the infirmary in a short time.

Dr. L. S. McMurtry: The subject of appendicitis has received a great deal of attention in medical journals and society discussions during the past two years. It is natural that it should, both on account of the vital importance of the subject and the fact that our knowledge of the disease, its complications and severe mortality, and its successful treatment are the work of American surgeons. Ovariectomy and the foundation of abdominal surgery laid thereby, together with appendicitis and its operative treatment, are among America's great contributions to surgery. While appendicitis has been so freely discussed and written about of late, there is much yet to learn of the disease, and the rules guiding operative interference are by no means clearly established. Appendicitis is the most common cause of peritonitis in the male, and if we study the mortality reports of any of our cities we will realize how common is the disease by the frequently recorded fatal report of males dying of peritonitis.

I do not know how I can contribute any thing to the interesting discussion of the evening better than by exhibiting a specimen and reporting some cases illustrating the several phases of appendicitis.

No. 1. Here is a vermiform appendix which I removed by abdominal section one week ago yesterday. It is the largest appendix I have ever seen—it is as large as a section of the distended ileum—thickened by inflammatory exudate, and ruptured at this point. At least three ounces of foul pus were poured into the peritoneum. The case in which this appendix was removed has a history which I would ask you to contrast with that of another case which I will relate further on.

The patient is a woman aged thirty-four years. She has been ill more than a year, being confined to bed for days, and then up and about for a time. For several weeks prior to her removal to this city last Saturday week she was confined to bed with acute peritonitis. She had a temperature of 104° F., pulse 130, sweating copiously, and distended abdomen. I opened the abdomen in the right semi-lunar line, and evacuated a quart of foul pus, and after separating adhesions removed this huge appendix, irrigated with two gallons of hot water,

and packed the iliac fossa with iodoform gauze. She reacted well; the pulse and temperature came down promptly, and she is now convalescing smoothly.

No. 2. Now compare the case I have just mentioned with one that I saw in Georgetown, Ky., last Monday in consultation—a gentleman, fifty-four years of age, who occupied a very distinguished position in the educational affairs of Kentucky. He suffered with *la grippe*, and had been in bad health for two years; traveled in Europe last year for his health. He was taken sick one week ago last Friday; his physician was called, and the patient seemed to be suffering from an attack of colic. The next day he had a little pain, and complained of a symptom that I have seen in a number of cases of appendicitis, very severe pain in the head of the penis, and retraction of the testicles. He went along in this way until Friday evening, when he was taken worse; still suffered from pain in the bowels and constipation. He had temperature of 100° to 100.5° F.; pulse never went above 100. His physician, Dr. J. A. Lewis, recognized the serious character of the disease. I saw him first on Tuesday of last week. The bowels had moved in response to an enema; there was no tumor in the right iliac fossa; there was a little resistance on that side of the abdominal muscles, but they were not rigid. He had a pulse of 88. I saw him again the next morning, and he seemed somewhat better; bowels had moved; he had taken some nourishment, pulse 82, abdomen softer, no tympany, no tumor, and the fever seemed to be subsiding. That morning I took the train and came home. At nine o'clock that night I received a telegram to come immediately, as the patient was very much worse. In an hour afterward I received a second message not to come; the patient was dead. A *post-mortem* was made, and perforative appendicitis with abscess was the cause of death.

Now contrast this history with that of the first case reported by me, where the woman had been sick a year, and where the appendix had undergone all of these pathological changes, which we see are very extensive. Of course the most important feature in connection with this subject is when operative interference should be resorted to. Prevailing professional and public sentiment will not support a surgeon in operating in a case like that of the gentleman at Georgetown. There is little risk connected with the operation in skilled hands, and I believe if we had opened this man's abdomen, we might have saved him, although his general condition was very unfavorable for resisting any

disease or repairing any injury. I would invite attention especially to the fact that there was no tumor, very slight elevation of the temperature, pulse under 100, nothing to indicate perforation and abscess besides pain, retraction of testicle, and pinched features. The diagnosis of appendicitis was made positively, and this case adds to the facts already recorded that an operation should be done when a diagnosis of appendicitis is established. The risk of waiting for symptoms is far greater than that of the operation.

Dr. W. H. Wathen: I will allude briefly to one or more of the cases that have been reported, and give my experience in connection with cases of this character. It is difficult to decide in many of these cases when to operate, because of our inability to make a correct diagnosis. Persons who are engaged in this kind of surgery or in abdominal or pelvic work are constantly reminded that when the abdomen is opened they find a condition that they had not expected, and that which they had expected is often entirely absent. I have seen a number of cases, where the subjective and objective symptoms indicated appendicitis better developed than in most of the cases upon whom laparotomies have been performed, who recovered permanently without operation, or in which the diagnosis was not correct. Some of these patients had a temperature from 101° to 104° F., obstructed bowels, rapid pulse, and a tumor the size of a large orange in the location of the appendix. I saw one of these cases before any operations for appendicitis had been performed. She made an uninterrupted recovery, and now, twelve years afterward, is perfectly well, and has had no symptom of a recurrence. Another case, a banker in this city, three years ago had a tumor larger than a goose's egg in the appendicular region, with pulse 120, temperature 103° F., and all the symptoms of appendicitis. He was not operated on, and in seventy-two hours the tumor had disappeared and his temperature and pulse were normal, and within less than a week he made a trip to Knoxville without inconvenience, and has had no symptom of a recurrence of the disease. I operated upon a patient last summer who had had three attacks of what was diagnosticated by excellent physicians appendicitis, and upon one or more occasions the several doctors in attendance decided that she could not recover; she vomited fecal matter. However, she recovered from these attacks. In the operation the appendix was found to be perfectly healthy, but there were extensive peritoneal adhesions binding large coils of the intestines together, probably caused from an injury she received three years before

when thrown from a buggy. I could report a great many instances of mistaken diagnosis, where the symptoms were just as marked as it is possible for them to be.

While appendicitis is usually intra-peritoneal, it is sometimes extra-peritoneal, as in the case reported by Dr. Vance. These are rare cases, but they do occur. Extra-peritoneal abscess in the right inguinal region with no involvement of the appendix is sometimes reported as appendicitis. These abscesses do not always point in the same direction. I have seen several cases where the abscess pointed toward the buttock, and in one case when it was opened I could introduce my finger deep in the pelvis, between the bone and Poupart's ligament. This abscess contained nearly a gallon of pus. I am sure the appendix was not involved. About the only positive evidence that the appendix is involved is the fecal matter in the abscess. Recently I treated a case of this kind. The pulse was 140, and the temperature 105° F., with a well-marked tumor, all the symptoms having existed for ten days. I made the usual incision and removed a pint of pus, in which there was a fecal concretion the size of the end of my little finger, showing that the trouble was in the appendix. Had there been no fecal matter in this case, no one could have said positively that it was appendicular in its origin. This case, like one reported by Dr. Vance, had no further fecal matter in the cavity. It was packed with iodoform gauze, and the patient made an uninterrupted recovery, having no elevation of temperature the morning after the operation.

In the case reported by Dr. Vance, in which the gentleman was attacked very suddenly and fell, I am inclined to the opinion that it was not appendicitis; for if the appendix is not normal, it is so little diseased that it could not have caused such symptoms as were manifested, particularly the suddenness of the attack. I believe there will be similar attacks in this case.

Referring to the Georgetown case, it is probable that the trouble was appendicular, but that could not be proven without a *post-mortem* examination, for, as I have remarked, the subjective and objective history of these cases very often will not enable us to come to a conclusion that is always correct.

Dr. Vance: To what other cause would you attribute the acute peritonitis with the tenderness, tumor, etc., in the right iliac fossa of the male, except the appendix?

Dr. Wathen: It might have been caused by a pelvic or abdominal

abscess with no involvement of the appendix; psoas abscess, renal or peri-renal abscess, abscess of the liver or gall-bladder, etc. It is one of the difficulties that we have to labor under in these cases to determine exactly what the nature of the trouble is. As a result we operate where the operation is not indicated, and, again, refuse to operate upon cases that require surgical interference.

Dr. C. W. Kelly: As regards the relation of the peritoneum to the cecum and appendix vermiformis, very frequently it is found that the peritoneum embraces only one half of the cecum as it extends around the appendix; occasionally it entirely surrounds the cecum and the appendix vermiformis; occasionally it goes entirely over the cecum, so that it may be either an intra- or extra-peritoneal structure. The appendix has a small mesentery of its own, which may not entirely close behind.

In regard to operative procedure for appendix, I want it understood that I am an advocate of surgical interference in these cases when it becomes necessary, but the most important point is to determine just when it is a necessity.

Dr. Dugan: I would like to call attention to another symptom which is sometimes present in appendicitis, and that is cystitis. I have seen several cases having this symptom. I think there is no mention in the text-books up to 1884 of involvement of the penis or bladder in appendicitis.

Dr. A. M. Cartledge: I was very much interested in the cases reported by Dr. Vance, and am not inclined to say that we are discussing appendicitis too much. I fully agree with Dr. McMurtry that a classification should be made of these cases, by which we can have some rational means of determining cases demanding operative interference, and the time at which the operation should be done. As surgeons I think we are all indebted to Prof. Kelly for the correct position he has taken; we are also indebted to Treves for his valuable work upon this subject. Read any medical journal and we find almost as many opinions expressed as there are writers in regard to the operation for appendicitis, whether the abscess is intra- or extra-peritoneal, etc. In regard to Dr. Wathen's remarks, I think it has been fully demonstrated that the appendix may be the offending organ, whether the abscess is intra- or extra-peritoneal, and that in either case we may have fecal matter in the abscess. The appendix is usually found to have a mesentery, but frequently it is held in place by simply a band of connective tissue posteriorly, and may

rupture either posteriorly or anteriorly through the anterior covering, and you can have a fecal abscess either intra- or extra-peritoneal.

Concerning the case reported by Dr. McMurtry, in which he says the trouble was appendicular in origin, and that large quantities of pus were evacuated: In most cases, especially those that recover, we have a circumscribed peritonitis and the abdomen proper is not opened. I believe that where you have rupture before protecting adhesions or walls are formed, in ninety-nine cases out of a hundred, if operation is performed and the cavity is washed out, the patients will die from septic infection. I believe every case characterized by acute pain, like the case reported by Dr. Vance, where the man fell on the street, is going to be followed by rupture of the appendix, and early operation is imperatively demanded. I believe that pain is our chief guide, and of more importance than elevation of temperature or tumor in these cases. I saw a case recently with Dr. Chenoweth where a man had several recurrent attacks of appendicitis from which he recovered apparently. He came to the city one morning, and was taken suddenly with severe pain in the abdomen, having many symptoms of colic. From the previous history of the case we diagnosticated appendicitis, and he was operated upon a few hours afterward at the infirmary. The appendix was removed and was found to be greatly distended, and popped upon being severed. I believe that this appendix would have ruptured in less than six hours from the great distension.

In regard to what Dr. Wathen says about the diagnosis being obscure: This is simply a greater demand for the expert physician. As before stated, I believe that where there is severe pain, with or without rise in temperature and tumor, these cases should be operated upon, and if the appendix is found diseased, remove it, whether diagnosis of appendicitis has been made or not.

Dr. Wathen: I did not say that presence of fecal matter in the pus was an indication of intra-peritoneal abscess; I reported a case of extra-peritoneal abscess where there was a fecal concretion in the pus. I said that fecal concretions or fecal matter in an extra-peritoneal abscess was an evidence that it was appendicular in origin.

Dr. Vance: I am thoroughly convinced that one of the most important things in a case of appendicitis is to know when the doctor should step out and the surgeon come in. My experience has been that doctors, instead of calling in a surgeon at the beginning of an attack, depend largely upon the judgment of the patient as to when he should be

called. This is a point that I think we should emphasize with the general practitioner, that the surgeon should be called to see the case early, since it is a necessity for the safety of the patient. I agree fully with what Dr. Cartledge has said, and think he has covered the ground very thoroughly. I believe that the safest plan would be to operate on all of these cases. An argument in favor of operation is that most cases of appendicitis recur. I have a case under observation now which ought to be operated upon; the man has a well-defined tumor as big as a duck's egg; he has had fever and severe pain; has been under opium, but his bowels have moved. I am sure that if this patient recovers from this attack he will have another. When I first saw him I advised operation, which was declined, and I have not seen him since. I saw a patient the other day with Dr. Tuley very much like the case reported by Dr. McMurtry, which he saw at Georgetown. The history of the case was such that it made the diagnosis more difficult. Patient was a boy, nineteen years of age, a carriage trimmer; he was in the habit of carrying tacks in his mouth, occasionally swallowing one. Dr. Tuley saw him twenty-four hours after the first appearance of pain, which was referable to the right iliac fossa, and advised operation. I was called in consultation, found pain in the left side, and the boy was considerably better. I thought possibly the trouble might be fecal impaction, and advised a high enema. This was done, the bowels moved, fever passed off, and he went on for five days seemingly convalescent; when suddenly he went into a collapse, evidently from perforation of the appendix or some other part of the gut, and died very quickly. I am sorry that I did not do an exploratory operation in this case, but I did not feel that the severity of the symptoms warranted it. It afterward developed that this patient had swallowed tacks a few days before he was taken ill. No *post-mortem* was held, so it will never be proven whether the tacks had any thing to do with the trouble.

Dr. Kelly: I have seen a great many cases of appendicitis and have never had a death result.

Dr. McMurtry: Many cases of appendicitis ending in death are diagnosed as idiopathic peritonitis, and so reported. The mortality from recurrent attacks of appendicitis is very severe.

Dr. Kelly: I do not want to be understood to even indicate that I do not favor operation for appendicitis, because I do favor it. I only claim that while a man's experience as far as it goes may be good, yet it must not be convincing. You may have five cases of appendicitis,

and four of them would require operation; again you might have ten cases and not one of them require operative interference. The operation can be performed almost without danger, and I believe in giving the patient the benefit of the doubt. I believe that many people might be saved by an early operation in cases where appendicitis was not made out.

JAS. S. CHENOWITH, M. D., *Secretary.*

Reviews and Bibliography.

Human Embryology. By CHARLES SEDGWICK MINOT, Professor of Histology and Human Embryology, Harvard Medical School, Boston. Four hundred and sixty-three illustrations. 815 pp. New York: William Wood & Co. 1892.

This most excellent and "comprehensive summary of embryology" will be a valuable addition to the library of the specialist and general practitioner as a work for study and reference. Too many theories on unsettled questions are given for the student to choose for himself, unless he choose the ones advanced by the author, but a work on a much less elaborate scale would suit his needs much better. The work is profusely illustrated with well-executed wood cuts, the index is thorough, and the bibliography, to which frequent references are made throughout the book, is full and comprehensive.

In his preface the author states that he has used as few technical terms as possible, as an instance stating he has discarded the words "epiblast, mesoblast, and hypoblast," but his innovations in regard to his frequent use of German terms when more comprehensive English or Latin ones could be used seems unnecessary, as all students of embryology are not good German scholars. He uses the term "genoblast" to designate the sexual elements. The author seems to have conclusively settled the mooted question as to the fate of the "Decidua Reflexa" by his study of four well-preserved normal pregnant uteri of two, three, five, or seven months' gestation, his study "justifying the theory that the reflexa undergoes hyaline degeneration and is absorbed."

Chapter V, on Theory of Sex, is an interesting one, in which the author gives his own and others' theories. The one following, on Heredity, is of interest also. Parts III, IV, and V, on The Embryo, The Fetal Appendages and The Fetus respectively, are exhaustively treated and well illustrated by specimens in the author's collection and well selected cuts from other works.

The work will doubtless be esteemed a classic in embryological literature.

H. E. T.

Diseases of the Chest, Throat, and Nasal Cavities: Including Physical Diagnosis and Diseases of the Lungs, Heart, and Aorta, Laryngology, and Diseases of the Pharynx, Larynx, Nose, Thyroid Gland, and Esophagus. By E. FLETCHER INGALS, A. M., M. D., Professor of Laryngology and Practice of Medicine, Rush Medical College, etc. Second edition, revised and enlarged. With two hundred and forty illustrations. 675 pp. New York: William Wood & Company.

While possessed of many features of excellence, this work is yet not one of those that leaves nothing to be desired. The arrangement of topics, while not distinctly incongruous, seems to have relation rather to the scope of the author's special studies than to general fitness. Physical diagnosis, for instance, requires the laying down of the text-book for demonstration during the prosecution of its study too often to be conveniently incorporated with other subjects. It may be said in its favor that the search for contributions relating to its several subjects has been thorough, and especially may this be said of the signs and symptoms of the several diseases.

A feature that is apt to challenge criticism is the frequency with which the author introduces the names of instruments of his own devising, or at least bearing his name. When an author claims to have invented twenty-five per cent of the instruments used in the treatment of the diseases covered by the title of this work, and names them for himself, one inclines to inquire whether he is actuated by egotism, by a desire for self-advertisement, or whether indeed he is possessed of a proportional genius.

The principal shortcoming of the work is not the fault, but the misfortune of the writer. He has not the faculty of impressing on his style a vigorous and at the same time a genial personalty which makes every thought his own, and renders the dryest subject entertaining. In treatment he is conservative and rational, and in the line, it would seem, of the most judicious experience.

D. T. S.

Syphilis and the Nervous System: Being a revised Reprint of the Lettsomian Lectures for 1890, delivered before the Medical Society of London. By W. R. GOWERS, M. D., F. R. C. P., F. R. S., etc. 131 pp. Price \$1. Philadelphia: P. Blakiston, Son & Co. 1892.

A work by Dr. Gowers, a word from Dr. Gowers, is always worthy attention, for it always repays attention and study. We have had many contributions in recent years on syphilis of the nervous system, mostly by men who knew more of syphilis than the nervous system, and some of them by men who had yet somewhat to learn of both. As far as matter is concerned, Dr. Gowers does not claim to do much in the way of original contribution in giving out this series of lectures, but in the method it is most valuable. The great burden of the work is the inculcation of correct diagnosis. This of course involves right treatment, for in syphilis the result of treatment is one of the best diagnostic tests.

The methods applied here to the investigation of syphilis are methods that might well be applied to the investigation of any subject, and are the ones pursued by Herbert Spencer in his evolutionary philosophy. First, the

probable causative relation of syphilis to various forms of nervous diseases is carefully considered, and then an effort is made to eliminate every possible source of error. The requisite procedures are regarded from every point of view, and no little repetition is indulged, but always such as the slow progress the mass of our profession makes in the knowledge of this class of diseases fully justifies. It is hard to see how an intelligent man could study this work and fail to be better qualified for the study of the class of diseases to which it relates.

In the prognosis of syphilis of the nervous system Dr. Gowers takes the same view as all the leading neurologists of the world. So long as the adventitious deposit causing the trouble is inflammatory, consisting of the peculiar gummatous element, the iodides and mercury are well-nigh sovereign for its removal; but the moment this is organized into fibrous or cicatricial tissue, then the prognosis is hopeless as to any improvement that shall depend on the absorption of this material.

The work is written in the vigorous, virile style that always characterizes the writings of the author, and is both eminently profound and eminently attractive as well as eminently instructive.

The author believes that individual restraint and chastity furnish the only prospect for the banishment of the disease from the earth. "With all the force," says he, "that any knowledge I possess and any authority I have can give, I assert that no man ever yet was in the slightest degree or way the worse for continence or better for incontinence."

D. T. S.

INJECTIONS OF THYROID EXTRACT IN MYXEDEMA.—Mendel (*Munch. Med. Woch.*, November 29th,) reports the results of treatment of a case of myxedema by subcutaneous injections of the extract of the thyroid glands of sheep. The patient, a woman, aged fifty-eight, was shown before the Berlin Medical Society four years since as a doubtful case of myxedema, developing after erysipelas and rheumatism. A month ago, however, the symptoms became very defined; she became very apathetic, with no idea of time or place; skin waxy-looking and bloated; eyes almost hidden from swelling of eyelids. There was edema over the lower part of the neck; the skin of the hands and feet was thinned, the nails splitting, and the hair lost. The axillary temperature varied from 94° to 97° F. Urine passed in small quantities; about 215 grains of urea secreted daily. Pulse of small volume; 60 per minute (formerly 70). Lower limbs hypersensitive to cold; hyposensitive to heat. After daily injections of thyroid extract the patient appears now much better, both physically and mentally. Pulse, 72 to 76; urine, 2½ to 3½ pints daily; urea, 310 to 540 grains; temperature, 95° to 97° F.; edema slightly diminished.—*British Medical Journal.*

Abstracts and Selections.

ENLARGED SPLEEN IN CHILDREN.—Kuttner (*Berl. Klin. Woch.*, Nos. 44 and 45, 1892,) agrees as to the uselessness of the percussion dullness in ascertaining any splenic enlargement in children. Dislocation of the spleen from pressure from above the diaphragm, and the very rarely movable spleen must be distinguished from the enlarged spleen. Acute enlargement occurs as in the adult, especially in the acute infective illnesses; among these illnesses, less generally recognized as causes of splenic enlargement, meningitis, vaccine intoxication, icterus, etc., are mentioned. As to diphtheria, there is some difference of opinion. In scarlet fever and measles enlargement of the spleen is frequently mentioned by writers. It may also occur in faucial angina and erysipelas. Sometimes, however, the enlargement has existed before the illness, and to avoid errors this must be borne in mind; changes in the size of the spleen may then be of service. Chronic enlargements may result from cardiac disease, and much more rarely from genuine portal obstruction. The enlarged spleen of malaria, leukemia, and pseudo-leukemia are well known. In sixty cases of rickets observed by the author the spleen was enlarged in forty-four. The first symptom of rickets—dyspepsia, intestinal catarrh, etc.—may exist for some time before the affection of the bones permits one to say that they are due to rickets. When discussing congenital syphilis as a cause, the author says that this affection leads in the majority of cases to rickets. He does not give any numbers in regard to the relation of this form of syphilis to enlarged spleen. A cachetic appearance, with a yellowish-white waxy-looking color is apparently only present in children when the splenic enlargement is considerable. Examination of the blood gives too variable results to be relied upon. A case of pseudo-leukemia is referred to in which many nucleated erythrocytes and many eosinophile cells, but no karyokinesis, were observed. The author thinks that pseudo-leukemia may be an early stage of leukemia. He refers to cases in which considerable diminution in the size of the spleen occurs under suitable treatment.—*British Medical Journal*.

HEREDITARY INFECTION.—Dohrn (*Deut. Med. Woch.*, September 15, 1892,) draws attention to the two separate systems of vessels in the placenta, and to the question whether the tissue separating them will allow of the transference of the syphilitic poison. Some breach of surface is necessary for the entrance of the syphilitic poison. Some materials can pass from the maternal into the fetal blood, but these are not of a corpuscular nature, as the syphilitic poison apparently is. Clinical experience bears out this view.

If mother and fetus are both syphilitic, not only the maternal but also the fetal placenta shows morbid changes. Again, if the child is very syphilitic and the mother healthy, disease has been found in the fetal portion of the placenta alone. Five such cases were examined by Rosinski. In no case in which a pregnant woman has been subsequently infected has the author seen the fetus born with any signs of syphilis. Although this evidence is negative, it is valuable when based on many cases. Maternal syphilis can lead to abortion without the fetus being infected. It is stated that mothers with syphilitic children acquire immunity against syphilis. They may nurse and suckle the children with impunity, and yet these children may convey the disease to another. It is said that the mother gets the disease through the fetus in minimal doses, and thus any momentary effect of the poison is weakened. The author thinks this a forced explanation, and that it is more likely that the initial lesion has been overlooked. The above-named immunity of the mother is not always observed. The author concludes that syphilis is only conveyed to the fetus at the time of conception, and that in this respect the sperm and ovum are equally potent. If the ovum is then healthy it will remain so, even if the mother be subsequently infected. If the mother has syphilis, it has been brought about through the father of the fetus, and not through the fetus itself. The syphilitic poison passes the placental separation neither from the fetus to the mother nor *vice versa*.—*British Medical Journal*.

CEREBELLAR TUMORS AND THE KNEE-JERK.—Dr. Handford, Nottingham, relates in Brain a case of some interest. The patient was a lad of sixteen, whose first symptom was apparently causeless vomiting. He subsequently suffered from headache and giddiness, with difficulty and unsteadiness in walking. When he came under observation he had an ataxic gait, and was subject to occasional fits, apparently of opisthotonic character. He also was found to have optic neuritis in both eyes, and he subsequently had some weakness of the ocular muscles and nystagmus. The knee-jerks when he was admitted were noted to be absent on both sides, but strangely enough ankle-clonus was present on both sides. Later this was not found. He became progressively worse, and, without developing any fresh symptom of importance, died six months after the onset of his symptoms. A tumor was found in the middle lobe of the cerebellum. Dr. Handford, in his remarks on this case, refers especially to the absence of the knee-jerks. He states the different views which are held with reference to the production of the so-called tendon reactions, and especially refers to the well-known views of Dr. Hughlings Jackson and Dr. Charlton Bastian with regard to the cerebellar influence. Dr. Bastian, in a paper read before the Royal Medical and Chirurgical Society some time ago, related the facts of several cases of total transverse lesion of the spinal cord, in which, in spite of marked sclerosis in the pyramidal tracts found *post-mortem*, the usual knee-jerks remained absent, a condition which was

referred to a cutting off of the cerebellar influence—the influence which, according to Dr. Hughlings Jackson's views, is responsible for the maintenance of muscular tone and the presence of tendon reactions. Dr. Handford regards his case as having almost the value of an experiment in showing the connection of the knee-jerks and the cerebellum, and goes on to say that, according to widely accepted views, the pressure of the tumor on the medulla should have produced descending sclerosis of the crossed pyramidal tract and exaggerated knee-jerks. We venture to think that Dr. Handford rather overstates his case when he says that according to widely accepted views the pressure should have produced descending sclerosis in the pyramidal tracts. It may be granted that in the presence of such sclerosis many would be surprised if the knee-jerks were not exaggerated; but that is a very different statement. We regret, with Dr. Handford, that the cord was not examined; but it would be interesting to know if the pyramids at the point at which the pressure was exerted were altered in any way. If they were not, then it may, with a considerable degree of probability, be assumed that the tracts were not degenerated. There is no doubt, as Dr. Gowers states, that in many cases of cerebellar tumor the knee-jerk can not be obtained, and that in the same case it is at times present and at others can not be elicited, and this fact may give a certain amount of support to Dr. Hughlings Jackson's theory. Even the facts of Dr. Handford's case suggest this variability in tendon reactions, for on one occasion ankle-clonus was elicited. This is certainly a curious and interesting fact, for it must be a very rare experience to find ankle-clonus present, a phenomenon which can usually only be evoked in an exaggerated state of the conditions on which the knee-jerk is supposed to depend, while the knee-jerk itself remains absent. The case, it will be seen, is one of unusual interest and suggestiveness, but observers will probably not agree as to the interpretation of its phenomena.—*London Lancet*.

SLEEP MOVEMENTS OF EPILEPSY.—Putnam (*Journal of Nervous and Mental Diseases*, August, 1892,) suggests that a study of the movements (apart from the mere restlessness of unsound sleep) occurring in some epileptics while asleep may possibly demonstrate that the site in which the discharging lesion originates is indicated by the movements. One patient, who usually had a fit about 10 P. M., was noticed by him to slowly raise her left arm over her head, momentarily hold it in that position, then let it slide down the pillow. The act was repeated several times within a few minutes. No fit occurred that night. In a young girl who had been epileptic for ten years definite sleep movements were habitual; the left arm was suddenly drawn up above the head, the left hand fell. When in a fit the body was drawn to the left side and the left fist rested on the corresponding shoulder. Removal of a layer of cortex from the arm center in the right cerebral hemisphere of this patient was not followed by any benefit.—*British Medical Journal*.

THE AMERICAN PRACTITIONER AND NEWS.

"*NEC TENUI PENNĀ.*"

Vol. 15.

SATURDAY, MARCH 25, 1893.

No. 6.

D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

A Journal of Medicine and Surgery, published every other Saturday. Price, \$3 per year, postage paid.

This journal is devoted solely to the advancement of medical science and the promotion of the interests of the whole profession. Essays, reports of cases, and correspondence upon subjects of professional interest are solicited. The editors are not responsible for the views of contributors.

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UNIVERSITY OF LOUISVILLE.

The Commencement Exercises of the Medical Department of the University of Louisville took place at Macauley's Theater on the 13th instant.

The audience was the largest that ever greeted a graduating class of this old and famous school. One hundred and ninety students, presented by the Dean, were invested with the doctorate at the hands of the Hon. T. L. Burnett, Acting President of the Board of Trustees.

The class valedictory was read by John Alfred Bodine, of Kentucky, under circumstances peculiarly sad. Its author, Robert W. Bowling, of Kentucky, upon whom the honor to represent it had been conferred by the graduating class, had been stricken just at the close of the college term with a disease that deprived him of both his eyes. This incident was told in appropriate words by the reader, and made a touchingly fit introduction.

The address was replete with thoughts such as possess the ambitious young man who feels that he has a destiny, and is impatient to take up the long and difficult march to professional success. It was a "youth's long ladder resting on a cloud;" but eyes not blinded by the dust of this too practical world might see "angels ascending and descending upon it."

The faculty valedictory was delivered by Prof. W. O. Roberts, subject, "The Incidents and Exigencies of the Physician's Life." The address was replete with wit and wisdom, and made a profound impression upon the hearers. It may be found in full text elsewhere in this issue.

The following is the list of graduates:

| | |
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| Anderson, Joseph Ray, Ky. | Carroll, Eugene S., Texas. |
| Aeton, James A., Ky. | Campbell, Henry J., <i>M. D.</i> , Ohio. |
| Alexander, Henry Francis, Tenn. | Daniel, George Preston, W. Va. |
| Archer, William Edward, Texas. | Davis, Owen, W. Va., |
| Abernathay, Thomas E., Tenn. | Dihel, Thomas Elmer K., Ill. |
| Athey, Wiley Lee, Miss. | Denny, George E., Ind., |
| Allhands, David S., Ky. | Denny, Charles W., Ind. |
| Bodine, John Alfred, Ky. | Dean, Charles G., Mo. |
| Beard, Frank M., Ky. | Dunaway, Enoch T., Ky. |
| Board, Milton, jr., Ky. | Ewing, William A., Texas. |
| Barker, John C., Kan. | Farley, William Floyd, W. Va. |
| Brady, John Alphonso, Ind. | Froedge, C. Wesley, Ky. |
| Benner, James Wemyss, Ky. | Faulkner, Albert Sidney, Ky. |
| Bloch, Oscar Edgeworth, Ky. | Fritschle, William E., Ill. |
| Bowling, Robert Walters, Ky. | Goldnamer, William W., Ky. |
| Blanton, William Pancoast, Texas. | Galbreth, William Henry, Ind. |
| Blackerby, Jed. O., Ky. | Gray, William J., I. Ter. |
| Bounnell, Harry Mathew, Ind. | Griffith, Joseph G., Ind. |
| Buck, DeWitt Clinton, Texas. | Green, Leonard T., Ind. |
| Brumley, Meritt C., Ky. | Griep, Otto C., Ohio. |
| Baugh, John H., Neb. | Gaines, William T., Ohio. |
| Bryan, George E., W. Va. | Gray, John B., Texas. |
| Bacot, Peter R., Miss. | Givan, Sanford L., Ky. |
| Bradford, William N., Ohio. | Gray, Henry, <i>M. D.</i> , Mo. |
| Boone, Frank C., Ind. | Hagan, Marion, Ky. |
| Buckner, William Thomas, Ky. | Hawkins, Martin Cassetty, Ark. |
| Bullock, Thomas S., <i>M. D.</i> , Ky. | Haberer, Charles Henry, Ky. |
| Campbell, David Aaron, Ala. | Huber, Mathew M., Ky. |
| Chambers, Edward, Tenn. | Hogg, Robert Letcher, Ky. |
| Cain, Silas G., Ky. | Hatfield, Henry Drewery, W. Va. |
| Crume, Squire Brown, Ky. | Halsell, Simeon Lee, Texas. |
| Capel, Joseph V., Ill. | Hardin, William M., Ky. |
| Cannon, Harry Ray, Ind. | Henderson, T. Martin, Ind. |
| Cline, George F., Ind. | Hunter, John R., Texas. |
| Coyle, Harry Bodley, Ky. | Highfill, William Eli, Ind. |
| Cloyd, Frazier N., Ill. | Hancock, Nathan M., Ky. |
| Casto, Fernando W., W. Va. | Head, Jones W., Texas. |
| Chilton, Philip H., Texas. | Huth, Frank Charles, Ohio. |
| Casto, Frederick S., W. Va. | Hensley, Edward Alfred, Ky. |

- Holcomb, L. Sherman, Ky.
Jones, Richard Mann, Ky.
Jennings, James Ladell, Texas.
Johnson, Joseph Eccleston, Ga.
Keller, William A., Ind.
Kendall, Arnold P., Ind.
Knoefel, Arthur Eugene, Ky.
Knox, Albert Henry, Texas.
Kessler, Martin C., W. Va.
King, Charles S., Ky.
Karlsioe, William J., Ky.
Keesor, James M., Ohio.
Lawrence, Graham, Ky.
Lillard, Gustavus D., Ky.
Langsford, Guy, Mo.
Lockett, Stephen Evelyn, Texas.
Lett, Oswald Asa, Ind.
Long, Kelon H., Mo.
LeMaster, Robert R., Texas.
Lavin, William, Ky.
Longstreth, Wallace M., Ohio.
Liles, Joseph L., Ky.
Lehane, Timothy Dennis, N. Y.
Lowry, Joseph William, Ohio.
Littlepage, Buckner, Ky.
Logan, Edwin Wilson, Ill.
Martin, Joseph Emile, Ky.
Moss, Willis Ringo, Ky.
Murphy, Oliver C., Iowa.
Mitchell, Edward B., Ind.
Montgomery, Hugh L., Tenn.
Minton, Frederick P., Ky.
Miller, James Frederick, Fla.
Moses, Adolph, Ky.
Magness, Benjamin P., Texas.
Marquisee, Harold, N. Y.
Mahon, Lytton Simeon, Texas.
Murchison, Andrew Jackson, Tenn.
Melton, William J., Tenn.
McKinney, John H., Miss.
McElmurry, Henry Scott, Mo.
McMahon, John William, Ky.
McDonald, Claude Meredith, Ind.
McClendon, Arthur Alexis, Ala.
McGauhey, Archibald, Mo.
McCray, Orville, Ohio.
Neal, James Arlington, Wash.
Nutter, Tryphosa D., W. Va.
Phillips, Henry James, Ky.
Paynter, Lawrence W., Ind.
Parker, John R., Tenn.
Prichard, Robert Allen, Ky.
Pollock, Aaron Sherrill, Ark.
Phillips, William F., Ky.
Preston, Benjamin J., Texas.
Risque, William Ernest, Ky.
Rone, John Bosman, Ky.
Rupert, Leonidas E., W. Va.
Roll, Robert L., Ky.
Reagan, Isaac R., Texas.
Rappold, Joseph M., W. Va.
Rice, Edward N., Ky.
Rucker, Joseph A., Va.
Recobs, Robert M., Ind.
Rymer, Hosea M., W. Va.
Rogers, Robert C., Ind.
Sackett, Wallace A., Ind.
Sharpe, Henry C., Ind.
Sowell, Leonidas B., Texas.
Stuteville, Stephen Washington, Ind.
Smith, Leroy Ball, Ky.
Sharp, Joseph Addison, W. Va.
Stewart, John P., Ky.
Stillings, John L., Ky.
Stone, Oliver M., Ind.
Seay, Ezra V., Ky.
Sigler, Labe J., Ky.
Schaich, Joseph A., Ky.
Shaunty, George M., Ky.
Smith, R. Cloyd, Texas.
Sandlin, H. Greene, Ky.
Staats, Charles O., W. Va.
Sanders, Harry G., Ky.
Simons, Franklin D., Mich.
Shively, Omar S., Ky.
Smock, Stonewall Jackson, Ky.
Sheppard, Francis Marion, Miss.
Trenkman, Otto, Texas.
Tichenor, James Bryant, Ky.
Taggart, Robert Steele, Ind.

| | |
|------------------------------|------------------------------|
| Thomas, Francis Miego, Kan. | Woodall, Joseph Martin, Ky. |
| Thomas, Samuel Herschel, Ky. | Woods, Thomas Harry, Tenn. |
| Tisdale, Edward Wm., Texas. | Waldrep, Archie C., Ala. |
| Thomas, Jacob J., Ohio. | Walker, J. Wallis, W. Va. |
| Thacker, Robert E., I. Ter. | Wheate, Justus Marchal, Ind. |
| Toliver, John A., Ind. | Walker, William H., Ind. |
| Vaughan, William E., Ark. | Wainscott, Oscar C., Ind. |
| Veech, Lee R., Ky. | Wash, Bishop, Ky. |
| Van Dyke, George H., Texas. | Weeks, William B., Tenn. |
| Wallin, William Bridges, Ky. | Wilson, James B., W. Va. |
| White, Herbert Quincy, Ind. | Yeaman, Malcolm H., Ky. |

THE ALUMNI ASSOCIATION.—The successful attempt made last year to put the Alumni Association upon a permanent working basis bore fruit this year to the satisfaction of every friend of the school. A large meeting convened on the 10th at the call of the President, Dr. Samuel Manly, wherein measures of great interest to the alumni and the school were set forth and discussed.

The banquet, on the night of the 10th, was honored with a full attendance, and passed with a zest worthy the cause and the occasion.

THE SOUTHERN MEDICAL COLLEGE ASSOCIATION.—By order of its President, Prof. J. M. Bodine, this Association is called to meet in Nashville, Tenn., on the 20th of April. Questions of great interest relating to medical education will be considered. We trust that the attendance will be full, and that these questions will receive wise solution.

DR. SHLAPOBERSKI has found the caustic action of nitrate of silver in contact with iodoform, which it decomposes with a hissing noise, very efficacious in the treatment of lupus. In an obstinate case he scraped away all the large nodules and applied nitrate of silver, afterward covering the parts with collodion containing 10 per cent of iodoform. The treatment was renewed daily. In three months there was a decided improvement, and in seven months the parts were entirely healed. There has since been no recurrence, though more than four years have elapsed.—*London Lancet.*

Notes and Queries.

DEATHS OF EMINENT MEDICAL MEN.—The deaths of the following distinguished members of the medical profession have been announced: Dr. Heinrich Balmer, of Dresden, at the age of forty-two; he was one of the first observers who made use of Koch's discovery of the tubercle bacillus for the purpose of diagnosing phthisis; he also published, in conjunction with Prof. Fraentzel, some valuable researches on the use of creosote in laryngeal phthisis; Dr. Cazeneuve, formerly Professor in the Lille Faculty of Medicine; Dr. Schaffhausen, Honorary Professor of Physiology and General Pathology in the University of Bonn, who was a great authority on anthropological questions, at the age of seventy-six; Dr. Samuel Logan, Emeritus Professor of Clinical Surgery in Tulane University, New Orleans; Dr. K. F. von Willebrand, formerly Director of State Medicine in Finland, a post he held for twenty-five years, during which time he introduced many needful reforms; he was in his seventy-ninth year.

ANTI-RABIC INOCULATION OF DOGS AND A COW.—An interesting experiment is now being conducted by Dr. Gibier, of the Pasteur Institute. A short time since a setter, belonging to a wealthy gentleman who has a country place in New Jersey, developed hydrophobia, and before the character of the disease was recognized had bitten fifteen other valuable dogs, setters, and fox hounds, in the same kennels, and also a cow. The dog was then shot, and its body brought to Dr. Gibier, who inoculated two rats with virus obtained from it, with the result of producing fatal rabies in them. At the request of the owner the cow and fifteen dogs were then treated with Pasteur inoculations, and the result of the experiment is likely to attract considerable attention.—*Boston Medical and Surgical Journal*.

DIGITALIS IN PNEUMONIA.—M. A. Stritzover (*Meditzinskoï Obozreniï*, Nos. 15 and 16, 1892,) fully indorses Petrescu's statements (*Deutsche Med. Zeitung*, No. 70, 1890,) concerning the abortive treatment of croupous pneumonia by digitalis in large doses, R: Infus. fol. digitalis, 2.0 vel 4.0: 200.0, syr. simpl. 30.0, M. D. S. A tablespoonful every half hour. The whole to be taken in the course of twenty-four hours. The writer's nine consecutive cases show that under the influence of the treatment on the following day (that is, after the said mixture has been taken) the temperature falls from 40° C. to 38°, and the subjective state markedly improves, the patient feeling practically well. In cases in the incipient stage the lungs become free from abnormal signs in a day or two, while in more advanced cases complete resolution occurs about the seventh day. In none of the author's patients were any toxic manifestations noticed.—*British Medical Journal*.

Special Notices.

AMERICAN PREPARATIONS IN ENGLAND.—We note in the analytical records of the "LONDON LANCET" the following laudatory remarks regarding an American preparation; "ARMOUR'S ESSENCE OF PEPSIN is a very distinct advance in preparations of this nature."

Also in the report of the INLAND REVENUE OFFICE (Somerset House) as follows: "Upon analysis we find that the highly nutritious properties of ARMOUR'S NUTRIENT WINE OF BEEF PEPTONE entitle it to be classified as a FOOD, and as such it is not subject to the excise tax."

The Medical Profession have long needed the assistance of a valuable FOOD that is thoroughly digested and requires no action on the part of the digestive organs. ARMOUR'S NUTRIENT WINE OF BEEF PEPTONE is made from fresh, raw, lean beef (from which the fat and gristle have been taken) thoroughly digested, combined with Sherry Wine and Aromatics, forming a most palatable preparation ready for immediate assimilation. The stimulating properties have been carefully subordinated to the nutritious so that its administration even to children has in every instance proven highly satisfactory.

It is specially indicated in all cases where nutrition is faulty or insufficient, such as Cancer, Phthisis, Diabetes, Bright's Disease, Ulceration of the Stomach, and whenever a general toning or strengthening of the system is needed.

ARMOUR'S ESSENCE OF PEPSIN is too well known to the profession to need any comment from us, but we desire to state that we have had most excellent results from its use as a vehicle in administering such "DIGESTIVE DISTURBERS" as Iodides, Bromides, Mercurials, etc., because of its high digestive strength and grateful stomachic properties. The world-wide reputation and commercial standing of ARMOUR & Co. are guarantees of the reliability of the preparation bearing their name.

HABITUALLY MOIST FEET.—This is found most frequently in such persons as live well and take little exercise. Also in young women of a somewhat nervous temperament, who indulge in the pernicious habit of frequent tea-drinking. Aside from its unpleasantness, the danger attending on wet feet is acknowledged, and it is also not rare for persons so affected to have their feet and legs icy cold for long periods of time. In the editor's experience, the best results of treatment have been obtained from the employment of foot-baths of a strong solution of EXTRACT OF PINUS CANADENSIS (KENNEDY'S) every night, and the use of powdered boracic acid, or salicylic acid, mixed with lycopodium, oxide of zinc, or other inert powder, constantly applied inside the stockings.—*Dr. Jamison's Periscope in Edinburgh Medical Journal.*

Having used *McArthur's chemically pure* Syrup of the Hypophosphites of Lime and Soda for some time in my practice, it affords me pleasure to recommend it to my patients who are suffering from incipient phthisis, chronic bronchitis, and other pulmonary affections. In all wasting diseases I think it a most reliable remedy. It increases appetite and promotes digestion.—DAVID F. DREW, M. D., *Councillor Massachusetts Medical Society.*

THE DELIRIUM OF FEVERS.—Neurosine excels the so-called Coal Tar products in quieting the delirium of fevers with absolutely no deleterious effects upon the stomach or depressing action upon the heart.

Satisfactory results will be obtained from the use of Neurosine in all forms of Alcoholism. If given in drachm doses every few hours it effectually relieves the distressing effects of a debauch.

THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNĀ."

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No. 7.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

PARALYSIS OF LARYNGEAL MUSCLES, WITH CASES.*

BY WM. CHEATHAM, M. D.

Professor of Diseases of the Eye, Ear, Throat, and Nose, Louisville Medical College.

The larynx has nine muscles, four pairs and a single. Besides these there are three pairs belonging to the epiglottis: the thyro-epiglottis, inferior aryteno-epiglottis, and the superior aryteno-epiglottis. The posterior crico-arytenoidei widen the aperture of the larynx. The crico-arytenoidei laterales and the arytenoideus, assisted by the muscles of the epiglottis and the aryteno-epiglottis, close the aperture of the larynx. Those governing the pitch of the voice are the crico-thyroidei, assisted by the crico-arytenoidei postici, making the cords tense. The thyro-arytenoidei externi shorten, relax, and bring the vocal cords together.

The nerves of the larynx are the superior laryngeal and the inferior or recurrent laryngeal, both branches of the pneumogastric. The superior laryngeal supplies the mucous membrane with sensation, and the crico-thyroid, the thyro-epiglottic, and the aryteno-epiglottici muscles; the other supplies the other muscles, the arytenoideus receiving fibers from both.

Neuroses of the larynx may be either sensory or motor. Those of sensation may be anesthesia, hyperesthesia, paraesthesia, and neuralgia.

Gottstein and Lefferts have given a clinical classification of paralysis of the muscles of the larynx, and Mackenzie a pathological one.

*Read before the Louisville Clinical Society, February 21, 1893. For discussion, see p. 264.

I have seen cases of paralysis of the recurrent laryngeals, unilateral and bilateral, of the adductors, unilateral and bilateral, of the abductors, unilateral and bilateral, and of the arytenoideus.

One case of hysterical paralysis of the adductors, which I believe I reported to this Society before, was in the person of a merchant from one of our interior towns. As in most similar cases the muscles of the lips were also involved. A strong interrupted current with one pole in the larynx soon restored him his voice. I have seen several cases in females, some of them hysterical, and some catarrhal. Rheumatism may produce it, or it may be toxic in its character, depending upon lead or arsenic; lead here affects the adductors alone, as it does the extensors of the forearm. Anemia is a common cause. I have seen sometimes persistent but more often intermittent paralysis of one or both adductors in cases of lung phthisis, lasting for several years. Diagnosis is usually easily made with the laryngoscope. Prognosis in adductor paralysis is usually favorable. A brush applied to the larynx or sometimes the simple act of laryngoscopic examination gives relief. Emotional influences give relief frequently. Mackenzie cites a case taken from Herodotus, who speaks of a son of Cræsus who was dumb, but whose voice was restored when some one not recognizing his father was about to kill him. Paralysis of the abductors is a much more serious matter. Here we have the "Gate of Life" about to be closed. The cause may be neuropathic or myopathic. In three cases seen by Mackenzie during life changes were found in the muscles after death, while the nerves and brain were normal.

My object in presenting this paper this evening is to report four cases, one positively paralysis of the posterior crico-arytenoidei; another I am not so positive of, as it is in the person of a child but six months old, rendering a laryngoscopic examination almost impossible, and two cases of paralysis of the recurrent laryngeal nerves, the result of large aortic aneurisms. The last two cases mentioned died in a few days after I saw them of rupture of the aneurism. In these cases no operative interference was indicated, as the cords took the "cadaveric position" in which voice is partially lost, but respiration not much interfered with. These are all the cases of this trouble I can at present recall as having seen. The child referred to above was brought to me about one week ago. The mother said it had had the trouble all its life. As I stated before, the child is but six months old, and its only trouble is on inspiration; expiration is perfectly free; symptoms worse when asleep. The noise

it makes then in breathing can be heard all over the house. Its cry and crow are natural. It has no trouble in feeding; its mother says it is as healthy as any other child. After several efforts I could see the epiglottis and the vestibule of the larynx; the epiglottis is an exaggerated omega shape; I could discover no growth of the larynx. A growth of the larynx could give about the same symptoms. I have seen two similar cases in babies, or cases with similar symptoms, which were relieved by pulling the tongue well out, or by holding the children with their faces down. Both of these children had trouble in nursing, this child has none. The present symptoms are those indicative of paralysis or paresis of the cord abductors. I have never heard of a congenital case, unless this is one. Some one may suggest anesthesia for a laryngoscopic examination. There would be great danger attending it; any one undertaking it should be prepared for an intubation or a rapid tracheotomy.

The second case is in a woman, forty-five years of age, otherwise healthy. She has been examined several times by different doctors, and no cause for the abductor paralysis discovered. The trouble has been coming on for months. She has been treated for hysteria, so she says, having taken a gallon or two of asafetida and valerian. The breathing is so bad at night that policemen have rung the family up and asked if any one was being murdered. When she came to see me about six weeks ago I found expiration free, but inspiration very difficult; voice not much affected. She had had electric and other treatment with no relief. Symptoms made worse by exertion. The laryngoscope gave a perfect picture of paralysis of the post-crico-arytenoidei; the cords were nearly together; the chink enlarged somewhat on expiration, but nearly closed in inspiration; the shape of the cords and the difference in the rarity of the expired and inspired air accounts for this. I suggested that she again try electricity and add to it hypodermatics of strychnia nitrate. She reported in a few days with her trouble much increased; the cords looked some thickened and red; her lips were a little blue; she could not sleep well, and while talking to any one she would fall asleep. Believing the case now to be quite a serious one I suggested to the family either intubation or tracheotomy; they, of course, preferred the former.

This narrowing of the glottis leads to much damage in other organs. This interference of change of gases in the lungs drives the blood back to the right side of the heart, resulting in much damage to distant

organs. I did intubation last Thursday afternoon, four weeks, assisted by Dr. H. M. Goodman, her family physician, and Drs. Pusey and Moorman. I inserted with but little trouble an adult hard rubber tube. Vulcanite is better for the adult tubes, especially when used in such a case as this, as there is no membrane to plug them, consequently they are not so liable to be coughed out, weight to prevent it not being necessary, and calcareous deposits are not so liable to form on them, consequently they can be worn longer without a change being necessary; the weight being so much less they are not so liable to irritate the vestibule. The patient complained a good deal of the tube for several days; said she now gets too much air. There was some soreness on swallowing for a few days. Temperature for four or five days was 100° F. To-day, February 21st (Tuesday), temperature is normal; there is but little soreness on swallowing, and she says she sleeps better than she has for months; all drowsiness has disappeared, and color is good. She says she feels like a new woman. She eats solids and semi-solids sitting erect, but has to take fluids with chest lower than the rest of the body.

What is the future of this case? I am inclined to use the intubation tube as long as it can be worn, changing the tube for cleansing, and to utilize new points of pressure every four, six, or eight weeks, by this hoping in some months to get the cords fixed in the "cadaveric position," or if this can not be done, to nick or cut through each cord, then put the tube back. Whether or not this can be done without a preliminary tracheotomy I can not say. I will of course try it later on. I know of no measure of relief that will not destroy or partially destroy the voice; now, with the tube in position, the patient can make herself understood across a large bedroom. I believe, then, that the patient can, should no accident occur, by operative interference get free breathing with partial loss of voice. No book that I know of speaks of intubation for the relief of this difficulty. Tracheotomy is advised. Intubation has been successfully used in similar cases by O'Dwyer and others. Dr. O'Dwyer for one of his cases had a cylindrical tube made, so as to get more lateral pressure.

These cases are fortunately rare. A majority of them die of their own neglect, refusing operative interference, and others of neglect of their physicians, who turn them away as hopeless. A strange coincidence, if the baby's case is one of abductor paralysis, is that both cases live in the same neighborhood, within a square of each other.

While speaking of paralysis, I would state that in the last ten days

I have seen two cases of one-sided mydriasis, one of the cases with myosis of the fellow eye, one case of right third and fourth nerve paralysis, one of left third nerve paralysis, with atrophy of the right optic nerve with some of the muscles of deglutition involved, and another with paralysis of the right third, fourth, fifth, and sixth nerves. I also have besides the patient reported, which promises to be a lengthy one for intubation, a child, three years old, who has been wearing a tube twenty-three weeks for a growth of the larynx, the tube staying in at one time seven weeks without being changed, and a woman with phthysical laryngitis, who has been wearing a tracheotomy tube for nine months with perfect comfort.

LOUISVILLE.

SPECIFIC VAGINITIS.*

BY JOHN G. CECIL, B. S., M. D.

Lecturer on Gynecology in the University of Louisville.

Several questions relating to different phases of this subject are of sufficient interest and importance to justify further consideration; in truth, it would well become the profession to continue to agitate this well-worn theme until some more definite conclusions could be established than can yet be claimed. It is with this end in view that the suggestions embraced in this short paper are afforded, trusting that the discussion may crystallize our present knowledge into more definite shape. Perhaps a simple enumeration of the possible sequelæ and complications that may arise from specific vaginitis will not be out of place here. There is hardly another disease in the whole category of human ills that can boast of such a progeny. A partial list comprises inflammation and abscess of the vulvo-vaginal glands, vulvitis, endometritis, and endocervicitis, salpingitis, ovaritis, peritonitis, cystitis, pyelitis, nephritis, adenitis, gonorrheal rheumatism, gonorrheal ophthalmia, proctitis. Does not this list plead with burning eloquence the gravity, the importance of this disease to the human race, and for the untiring vigilance and zeal of the medical profession in grappling with it? and not only the medical profession, but civic authorities as well? The social evil has always existed. Judging the future by the past and present, it always will exist. I believe that licensed prostitution, with

*Read before the Louisville Clinical Society, February 7, 1893. For discussion see p. 255.

governmental inspection in systematic and regular manner, and compulsory sequestration and treatment by competent physicians, will do more to limit the spread of gonorrhea than any other means yet suggested. It would require years and scores of years of continuous effort to accomplish very many visible results.

This is a contagious disease, and must propagate by contagion. Its control therefore ought not to be an impossibility, any more so, at least, than any other contagious disease. I am forced to conclude that medical men are not as keenly alive to the terrifying consequences and possibilities of this disease as they should be. The popular fallacy that "a clap is no worse than a bad cold" has too many adherents in the ranks of the profession. This seems a justifiable deduction from the careless inspection of new and acute cases, the hasty prescription, the more hasty and imperfect directions as to the use of injections, douches, etc., and particularly the acceptance of a statement from the patient that the cure is complete, in lieu of a thorough and painstaking examination of every surface or canal involved. A valuable clinical point in differential diagnosis between simple and specific vaginitis, that is agreed upon by modern authorities, is that urethritis or endocervicitis, or both are always present in gonorrheal vaginitis.

As to the pathology of specific vaginitis we are still in perplexity. For many years after the discovery of Neisser we made obeisance to his gonococcus, but at present it appears to be the consensus of opinion that something in addition to the presence of Neisser's bacillus is necessary to the development of gonorrhea. What that something is constitutes the perplexing question. Experiments made by Neisser, Krausé, Löffler, Bouchard, Burner, and others demonstrate the failure of pure culture of the gonococcus to produce gonorrhea.

The question as to how long the specific virus of gonorrhea may retain its activity in the genital cavities is one of exceeding interest and importance, and one to which I have seen no conclusive answer. This question is often put relative to a prospective marriage, or as to how soon after an acute specific inflammation of the vagina and urethra should a prostitute resume her avocation. It will be difficult to formulate a law applicable to all cases. Certain it is, however, that gonorrheal virus of propagating activity may lurk in the various pockets and glands long after all subjective symptoms have subsided. Herein lies the particular necessity for a searching examination of every gonorrheal patient before final discharge. This clinical fact is also the probable

explanation of the auto-infection of puerperal women, a class of cases that make much work for the pelvic surgeon.

Treatment. Under this heading it would be difficult, even if it were necessary, to suggest any thing new pertaining to medicaments. I am prepared to admit that many of the different lines of treatment at present in vogue are efficient. The success or failure of any particular method of management depends more upon the guiding hand and the strict adherence to directions explicitly given than upon the medicine used. Many of the popular prescriptions and injections will be found satisfactory, provided the details of management are faithfully carried out. Given a case of acute gonorrheal vaginitis, it is well to divide the treatment into three stages:

First: In the initial stage of acute suffering with active inflammation the treatment should be of soothing character, the injections of very mild solution, and given in large quantity. Nothing is preferable to corrosive sublimate in strength of 1 to 10,000 given warm, and with it an anodyne such as cocaine or morphine if necessary to relieve pain. Diluent drinks are serviceable, and rest is imperatively demanded.

Second: After the acute symptoms have subsided, the treatment should then be more vigorous and active. The strength of the douche should be increased to 1 to 2,000 or 3,000 of corrosive sublimate, and administered twice or three times in the twenty-four hours. It is just at this point in the treatment of a case that the discipline necessary to a complete cure is likely to be relaxed; the suffering gone or relieved, the patient naturally concludes that strict attention to directions is no longer obligatory. Many cease the treatment altogether, and so are only half cured, or really are not cured at all, but go to fill up the ranks of chronic or latent gonorrheas. Another point that should be most strenuously enjoined is the proper method of administering the douche. The fountain syringe or douche-can should be used in order that large quantities can be given; the douche point should be of glass, and should be immersed in a carbolic-acid solution when not in use. The patient must be in the dorsal decubitus with hips elevated. The doctor ought to give the first douche himself, and so instruct the nurse who is in charge of the case as to the exact detail of each subsequent douche. The glass point is introduced the entire depth of the vagina, and with two fingers of the disengaged hand every pocket or cul-de-sac and the sulci between the vaginal rugæ are opened up or spread out so that the

medicated wash reaches every part of the diseased surface. It is apparent that no woman can properly administer a douche to herself. After the injection a tampon of iodoform gauze is left against the cervix uteri. For the accompanying urethritis a pencil of iodoform is left in the urethra twice daily.

Third: If chronic vaginal inflammation or cervical catarrh persist after a treatment carried out in thoroughness of detail as above indicated, it is probably due to extension of the disease into the cervical or uterine cavity, and attention is now directed to these localities. Treatment now to be efficient must be radical. Cervical dilatation followed by curettage with a sharp curette to the extent of destruction of the lining mucosa, or Schroeder's operation of excision of the cervical mucous membrane, are indicated as the best methods of curing chronic or latent vaginitis due to gonorrhea. Management of specific vaginitis as above suggested will assuredly result in fewer cases that are pronounced incurable, and in fewer cases that by extension of the infection to the fallopian tubes and ovaries are relegated to the pelvic surgeon for permanent relief only after irreparable damage has been done.

LOUISVILLE.

NEURASTHENIA.

BY J. S. LEONHARDT, M. D.

When the Committee on Nomenclature reported back to the Royal College of Physicians a list of eleven hundred and forty-six diseases as being the sum total of all the variations from health to which the human being may be subjected, neurasthenia was not mentioned. Neurasthenia then is not a disease, but simply a name applied to a large group of symptoms that obtain in many diverse forms of functional nervous exhaustion, acute or chronic, local or general. I will not be so presumptuous as to think that a proper classification of all the symptoms of this condition are possible at the present time. If the reader will consent to a bird's eye view of an interminable swarm of neurotic exhibitions, he will not have wasted his time on this effort.

That some people are born with nervousness, that others acquire nervousness, and that some have nervousness thrust upon them, is a truthful parody. "Every school-boy knows," as Macaulay would say,

that sick headache, neuralgia, fits, insanity, etc., "run in the family," and they are instances of those whose children will be born with nervousness. The youth in hot pursuit of knowledge, by way of the cormorant method now fashionable, and which enables him to rush into some business, trade, or profession long before the eider down has left his face, or he who is engaged in the occupation of sowing a vast acreage of "wild oats," is accumulating for himself and his unlucky posterity a fund of nervousness so liberal and conspicuous that it will surprise him some day. The maiden who follows suit, but instead of engaging in some useful work lounges all day on a large, soft sofa in a hot, dry atmosphere, reads fiction by Michelet, Zola, Flaubert, etc., *ad nauseam*, draws a "dead line" between good digestion and common sense by means of a corset many sizes too small for her already little pale body, who avoids the energy of the sun's rays as I would the poisonous exhalation of a Florida swamp, forgetting that the voluptuous blush of the peach is caused by solar kisses and daily baths of cold dew, she too will awake one day to a similar surprise. Such people are examples of acquired nervousness. When in agricultural districts the sky withholds its liquid treasures, and breathes instead the blighting breath of the hot south wind, tillers of the soil and owners of great herds have nervousness thrust upon them, especially when they remember their domestic and financial obligations. In the dead of night, when the assassin, the incendiary, and the libertine are busy at their infernal work, the morning will dawn not only on broken hearts, but shattered nervous systems. When gigantic institutions of commerce or finance tremble for a moment and then go down with a crash that reverberates throughout the civilized world it echoes for a long time in the nervous systems of its victims, echoes that startle into activity or intensify already existing diseases such as cancer, skin diseases, epilepsy, insanity, drunkenness, suicide, and crime.

This condition, while it may shorten and greatly embitter life, does not often kill outright, yet such an event is possible. A person lost in a dark, cold, stormy night may die and not have been frozen to death; a swimmer, making violent efforts to save himself from a watery grave, may perish in the water and not have been drowned, both having been killed by acute nervous exhaustion. It is among chronic neurotics, the kind most commonly encountered in practice, that brilliant cures are often possible, for there are but few who are hopelessly incurable. If I were asked to describe one of these sufferers I should select one representa-

tive of a class "that is the heir of every true neurosis from insanity to toothache," the intellectual neurasthenic. He is a David rather than a Goliath; small boned, symmetrically built, with muscles small and fibrous, but wonderfully firm and filled with strength. He is energetic and untiring, can do the work of two in half the time, and get along with but little food or sleep. His head, sparsely covered with fine hair, is generally well shaped, and sometimes large. His senses are acute, his feelings sensitive, and his memory is a perfect mirror of the past, reflecting benefits and injuries with equal facility. He does not trifle with strong drink, neither does he tempt himself with any form of opium or other narcotic, for he is too observing not to have seen that in people of his trend "the chains of intemperance are but silken threads when compared with those of the opium or chloral habit." Such as he never reform; if they fall they are irretrievably lost. He is eccentric, odd, brilliant abroad, and sullen at home. He is full of schemes and nameless peculiarities. He can plan and contrive enough to keep a regiment at work for a century, and yet rustle away ten or twenty years without being able to point to a single completed work, or, if completed, that bears the least resemblance to what it was at its inception. The bewildering pace of modern progress is even too slow for him, and he fancies that he is far in advance of the age, hence the want of appreciation that haunts him always and everywhere. This busy, restless, untiring mortal can usually find among his immediate or more remote ancestry numerous cases of rheumatism, gout, consumption, scrofula, syphilis, alcoholism, renal disease, spinal trouble, paralysis, fits, insanity, crime, etc. He sedulously avoids this disagreeable feature of his antecedents even before his confidants. He knows he is a little predisposed to nervousness, but is not pining for an opportunity to tell some one of it. He would hardly admit it to his physician, unless the medical man first read it in his bright twinkling eye, pallid cheek, and high collar bone when he is being examined for a goodly sized block of life insurance, for he is provident, and would not have his family insulted with the fact that he had left them unprovided with money in case of his death.

Let us follow this Proteus a little further. It is an interesting study.

Neurasthenia is not a disease proper, because it has no constant pathological lesion. It is known to most people by the name of general debility, nervous weakness, nervous prostration, nervous exhaust-

ion, nervous debility, etc.; to physicians generally by the same and other names more learned and therefore dignified, such as neuratrophia, the neurotic diathesis, and its old army appellation, "irritatio spinalis." Among the characteristics of this condition may be mentioned a loss of tone, vigor, and finally material in the nerves of the brain, spinal cord, and great sympathetic. Its strange and always distressing symptoms find expression in the unnatural behavior of the sensory, motor, psychological, and visceral departments of the whole economy. It renders the subject an easy victim to the ravages of a multitude of diseases, especially epidemics. It accompanies a majority of chronic ailments in their career. It is present in all tardy convalescences. It frequently continues long after the acute or chronic disease that caused it has been forgotten, such as some zymotic disease or eruptive fever, an ancient diarrhea, unimportant hemorrhoids, or an exhaustive discharge of any kind. It is intensely interesting to follow its curious wanderings in the histories of families. Parents or ancestors afflicted with some form of nervous disease mentioned under my description of a neurotic person will transmit the most varied and peculiar forms of nervousness, and often to a very remote posterity. It is a regular attendant upon that irregular and forced mode of life which is the legitimate offspring of the present age, an infant more lusty and boisterous in the United States than in any other country under the sun, not only on account of its climatology, but because it is here that physical and mental toil is so common and so excessive, whether it be the labor of the artisan, the intense mental concentration of the inventor, the financial prowess of the speculator, or the politic strain of some renowned leader of a political faction. Its victims may also be found, and that by the score, among the physically and mentally lazy, retired farmers, suddenly enriched plebeians, inane fops, and also those who spurn the ordinary knowledge taught by the ministry of the physical sciences, and pose as students or heroes of occultism or the hermetic philosophy.

It frequently results from sexual diseases, abuses, and injuries; from mammary, uterine, and ovarian irritation in women; stricture, cystitis, and prostatitis in boys and men; from railway accidents, great grief, fright, or profound impressions of any kind. It commonly results from prolonged or aggravating irritation, mental or physical, such as discordant sounds, shapes, and colors. Chronic catarrh, defective vision, being maimed for life, as suffering the loss of a limb, or a prominent and conspicuous disfigurement, are all common and prolific sources of most

inveterate neurasthenias. I have known a luxuriant corn on the little toe of a little girl to initiate and maintain a most perplexing array of nervous symptoms. A seamstress found it necessary to change employer because, forsooth, in front of the window where she worked grew a deformed and very neglected old ash tree. She found herself unconsciously comparing its ugliness with a repulsive dwarf she knew, and it "made her awful nervous," as she expressed it. Intermarriage of blood relations will often arouse a surprising amount and quality of nervousness in both parents and offspring. It is most common among the middle-aged without regard to sex, in whom it may have been sleeping since early childhood, during which time it may have shown itself in the form of oversensitiveness, unusual beauty, precocity, or the reverse of the same, night terrors, or an infinite variety of strange fits and indescribable "spells." Houses heated with hot air are excellent incubators for neurasthenia. Hot, dry air in a room acts exactly like hot, dry air elsewhere. It absorbs the moisture of the body, causes a wrinkled, withered condition of the skin, and, being a poor conductor of electricity, allows the body to become surcharged with static electricity, rendering the nervous system abnormally sensitive to all impressions, both peripheral and internal. Extremes of temperature and sudden meteorological changes are potent in the causation of neurasthenia. In evidence of this, observe the condition of those who dwell in lands that have all weather and no climate—any great inland country.

Lest I might weary the patience of the reader, I shall forbear mentioning any thing relative to the symptomatology, prognosis, and treatment of neurasthenia at this time.

LINCOLN, NEB.

THE HARVARD VETERINARY SCHOOL.—The report of the Dean of this school, contained in the annual report of the President of the University, states that: The school has now been ten years in existence. It began with gifts for immediate use amounting to \$2,500, and has never received any more. It began with ten students and now has forty, notwithstanding the fact that it has constantly labored under the disadvantage of fighting the battle for a long curriculum against a well-established short one. It has a three-years' course, the largest corps of instructors, and the widest range of instruction of any English-speaking veterinary college. The institution of courses in pathology, helminthology, and meat inspection is recommended.—*Boston Medical and Surgical Journal.*

Reports of Societies.

THE LOUISVILLE CLINICAL SOCIETY.*

Stated Meeting, February 7, 1893, Dr. J. M. Krim, Vice-President, in the chair.

Dr. W. O. Roberts: (Spastic Paralysis from Central Lesion.) This patient is eight months old. At the time of its birth the mother had a hard and protracted labor, and was delivered with instruments. She noticed soon after birth of the child that it did not have any use of one arm, that it seemed to be turned or twisted to one side. The arm was adducted and rotated inward. Six months after birth (two months ago) the child was taken to a surgeon in a neighboring city, who said there was dislocation of the shoulder, dislocation of the elbow, and a fracture of the forearm. He worked with it, put it in splints, and had it under treatment for six weeks. The splints were removed after he went home. The family say that the arm is in very much better condition than it was when this gentleman saw it. By examination now you will notice that movements of the elbow are very good, as are those also of the wrist; pronation and supination seem to be all right; but there is limited motion at the shoulder-joint, and in examining the axilla you will find that the pectoralis minor muscle is tightly contracted. The hand on the affected side is very much smaller than that of the other side, and the fingers are in a flexed condition, but can be straightened out. There is little or no difference in size of the two arms. A peculiar feature of the case is that the anterior fontanelle is entirely closed, which rarely happens at the age of eight months.

DISCUSSION.

Dr. T. P. Satterwhite: I think the case is one of spinal trouble. It is not an uncommon thing for children to be born with paralysis of some of the muscles. There was a gentleman in this city born with paralysis of the deltoid muscle, and that was the only muscle in the arm that was paralyzed. When I saw the case the man was about thirty-five years of age, and had never had any use of that muscle. This case is one of central nerve lesion.

*Stenographically reported by C. C. Mapes, Louisville.

Dr. Roberts: The doctor who saw this case claims to have reduced two dislocations and set a fracture. There is now apparently no evidence of a fracture having existed, no callus or any thing pointing toward fracture, and it has been only two months since he first saw the child.

Dr. J. G. Cecil: I hardly know what to say about the case, the history is so uncertain. Having to depend upon the family to give an account of an obstetrical case makes it a very unsatisfactory and uncertain sort of history. It struck me at first that it must have been simply a dislocation of the shoulder which had been produced in the delivery. As you know, we sometimes have difficulty in delivery of the shoulders even after the head has passed with comparative ease. I saw in consultation a case not very long ago of forceps delivery, in which there was an occipito-posterior position, delivered with forceps after pretty hard effort, and the shoulders failed to rotate into the antero-posterior diameter of the outlet, making delivery very difficult, so much so that both my consultant and myself thought it very probable that there would be injury to the shoulder-joint, but fortunately, even although we had to use considerable force in delivery of the shoulders, no injury was done. I can very readily see how in this case there might have been detention of the shoulders, and a blunt hook could have been introduced into the axillary cavity and the shoulder brought down, and the consequent injury from this procedure. But if there had been a dislocation of the shoulder, I fully agree with Dr. Roberts that there ought to be more evidence of it now. The reduction of a shoulder-joint dislocation in a child after six months' standing would most certainly show more evidence than we find here.

The question as to whether it is central lesion or spinal trouble is one that seems to me to be in a good deal of doubt. I thought from the peculiar crease upon the child's head that possibly it might have been the result of forceps injury, but the mother says the head was not marked at all by instruments. It is also unusual that the anterior fontanelle should be entirely closed at the age of eight months, yet I can not see how that would have any effect upon the subsequent history of the child, except by possible interference with development of the brain. The history is so uncertain that it seems to me it would be very hard to get at a correct diagnosis in this case.

Dr. Roberts: I can not think that there was any dislocation, because, had there been, the arm would not have been brought close to the side

and twisted in this way; it would have stood out more. It is a case of spastic paralysis from central lesion. I think the physician who treated the case simply improved the position of the arm by stretching the contraction. Then again the wasting of the hand and drawing in of the fingers would indicate central trouble.

As to treatment, now that is a point of considerable interest as to whether passive motion, massage, and stretching these contracted muscles will overcome the rigidity, or whether it would be better to divide the muscle in the axilla. My idea is, the best plan of treatment would be passive motion with electricity and massage for a couple of months, and then, if the trouble is not overcome, divide the muscle and stretch it. That will give motion to the shoulder. Then of course the muscles of the arm and forearm will have to be tested with electricity to see whether there is any paralysis.

The essay was read by John Cecil, M. D.; subject, Specific Vaginitis. [See p. 245.]

DISCUSSION.

Dr. F. C. Simpson (visiting): I do not think there is any question about numbers of these cases going on for months from no other cause than negligence in treatment. As Dr. Cecil says, the difficulty is to get at all portions of the vaginal canal. I believe this can be done if the case is properly managed. Physicians, I believe, are often very negligent on this point, which may account for numbers of cases being reported cured which afterward develop some pelvic trouble. I think it is advisable in these cases to take a sample of the discharge and have it microscopically examined to see whether all the gonococci have been destroyed. The trouble might apparently be cured; still, from lack of thoroughness, if any of the gonococci remained in any part of the canal or in the uterus there will be a return of the symptoms, possibly with such severity as to require operative interference.

Dr. P. Gunterman: Dr. Cecil has said about all there is to be said upon the subject. I do not agree, as far as my experience and reading goes, with the statement that urethritis is always present in specific vaginitis, but I do believe that cervicitis is always present, which I believe should be treated the same as vaginitis with douchings, and then you can make local applications to the cervix, carrying them up into the body of the uterus if necessary. A solution of corrosive sublimate, I think, is considered best by all authorities for use as douche in these cases, weak at first, and the strength increased afterward. I agree

with Dr. Simpson that it is advisable in these cases to have the secretion microscopically examined, and think it should be done by a very competent man, and even then there is doubt in my mind whether it can be proven in all cases that the vaginitis is gonorrheal in origin, as there is another coccus which so nearly simulates the gonococcus that they can not always be differentiated.

Dr. L. S. McMurtry: I think Dr. Cecil's paper is most opportune indeed. Until very recently the profession has regarded gonorrhea in the female as a trivial disease. There is a large proportion of the profession, even at the present time, that make no discrimination between leucorrhea of simple catarrhal character and specific vaginitis, all cases being treated as leucorrhea. It seems to me that the time has come when more attention should be directed toward the prevention of the severe sequelæ of gonorrhea, pyosalpinx, ovaritis, suppurative peritonitis, which require abdominal section, by giving careful attention to its treatment in its incipency. It is rather exceptional for patients with gonorrhea to seek medical aid early in the attack. I was greatly pleased to see that Dr. Cecil has interpolated on the back of one of his pages the sentence that "Specific vaginitis, as a rule, is accompanied by urethritis," and was surprised to hear such a close observer and profound student as Dr. Gunterman say that he did not agree with the essayist in that particular. It has certainly been my observation that specific vaginitis is invariably accompanied by severe urethritis.

The greatest defect, I think, in the treatment of specific vaginitis, as mentioned by the essayist, has always been that the physician treats these cases in a very desultory manner, advising the patient to use a vaginal douche, yet does not instruct her how to do so properly. It seems like a very simple thing to discuss at length, but it is a fact that very few practitioners inform a woman as to the position they should assume in taking a vaginal douche; that sitting over a basin and using a syringe forces down all the pelvic organs, preventing access to the folds of the vagina. I think a fountain syringe preferable to any other for this purpose. Instead of sitting over a basin, the patient should be in a semi-recumbent position, with a rubber cloth, such as can be found in almost every house, under her hips, which should be slightly elevated; then the nozzle of the syringe can be introduced into the vagina so as to reach all the surface. I have very grave doubts as to whether any woman is competent to treat herself by vaginal douches for gonorrhea efficiently. The treatment of this disease is the same as the treat-

ment of an abscess, and ought to be so regarded. I am losing my faith in antiseptic injections to cure gonorrhea. I doubt very much whether 1 to 10,000 solution of bichloride of mercury can make much impression upon virulent gonorrhea. I believe that every thing which is accomplished is done by flushing and by drainage. If you use simply hot water, placing the patient in the proper position, using two fingers in the manner described by Dr. Cecil, thoroughly flushing the vaginal surface, much good can be accomplished, and the oftener it is done the better. If you have the patients under control, and can get them to devote themselves to it, I think the vagina should be flushed with hot water from four to six times in the twenty-four hours during the acute stage; then pass a piece of iodoform gauze up to the cervix, so as to encourage drainage all the time in the intervals between. If this line of treatment could be followed out, our results in the acute stage would be more satisfactory. Of course this is sometimes impracticable, and as long as treatment is neglected and imperfectly carried out there will be a great many cases followed by endometritis, salpingitis, and peritonitis.

There is one point upon which I must differ with the essayist; that is, I do not believe we ought to open up the cervical canal and interior of the uterus until the indications for it are positive. By opening up these surfaces we may readily spread the infection over a field not yet invaded.

Dr. Cecil: In the paper I divided this subject into three stages, and indicated treatment accordingly. For the first stage I suggested that the solution of bichloride should be very mild (1 to 10,000) until after the acute symptoms had subsided, perhaps a week or two; then to attack the subacute condition with a stronger solution (1 to 2,000 or 1 to 3,000), and after that the third stage.

Dr. Geo. W. Griffiths: Do you not use acetate of lead and the other drugs that are known to produce good results in these cases?

Dr. Cecil: I stated that I believed the successful treatment of gonorrhea depended more upon thoroughness of detail in the management than upon the medicine used; that I was certain in my own mind that nearly all of the popular prescriptions would be followed by success if directions explicitly given by the physician were thoroughly carried out by the patient and her nurse. I have confidence in a good many drugs, and simply referred to corrosive sublimate as probably the best.

Concerning the douche point, I really do not think it makes much difference what kind of a point is used, or in what direction the current

flows, but the important point is to get the medicated wash, whatever you are using, to every part of the diseased surface, and that is why I dwelt upon so simple a matter as giving a douche. It is a well known fact that if you allow a woman to squat down over a vessel and give herself an injection with an ordinary syringe, with any kind of a douche point, whether the current runs one way or the other, there will likely be parts of the vaginal surface that will not be reached at all, hence chronic gonorrhea will result, and it will exist indefinitely unless a thorough line of treatment is persevered in. When a woman sits down over a vessel a portion of the vagina is practically shut off, and this is why I described so minutely the manner of taking two fingers and spreading out every part and fold of the vagina, having the patient in the dorsal decubitus with the hips slightly elevated. In this way you can be sure that the solution is carried to every part of the vaginal tract, and unless done in this way I do not think you can be positive that the douching has been thoroughly accomplished.

I do not know what proportion of cases of salpingitis, pyosalpinx, and pelvic peritonitis or abscess are due to gonorrhea directly or indirectly, but any one reading over a list of cases where trouble has been taken to ascertain whether or not there was the previous history of gonorrhea, it is simply astonishing to find how many of such cases give such a history, and for that reason it seems to me the importance of this matter can hardly be exaggerated. I think Dr. McMurtry and all men who do pelvic surgery will appreciate the importance of prevention. Certainly it is better if we can cure a case, and I admit all he says about the difficulty, and for that reason I took occasion to run off on to side issues and to say that I thought government control ought to be established over prostitutes, as they are the ones who promulgate the disease. We may not be able to exterminate it, but if we can prevent it becoming chronic and extending to the upper and more remote genital passages we are doing a great service to humanity. The subject of the suppression or cure of this disease is one I have often thought of, and one that I am glad to see has very recently been seriously agitated. In yesterday's Medical Record I noticed an editorial on this subject, and in the last week's Philadelphia Medical News another editorial upon the recent article of Neisser as to the proper management, control, and suppression of gonorrhea. I do not know how to express in words what the importance of this subject is to the human race at large. When we see all of this train of complications and after-results

of gonorrhea we certainly can not exaggerate it. I believe most of us will admit that we are often very negligent in the treatment of cases of gonorrhea. Gonorrhea in women is infinitely more serious than it is in men, and we all know from recent discussions, if we have not known it before, what terrible results follow the neglect of proper treatment in the male, but in the female it is infinitely more so. Consequently I believe a continued agitation of the subject especially called for, and by bringing it to the minds of the medical public generally good results will come.

In regard to the point mentioned by Dr. Gunterman, I think he will find recent authorities all agree that urethritis is an invariable accompaniment of specific vaginitis. That is really the only differential diagnostic point that can be made clinically between simple and specific vaginitis.

I do not know whether Dr. McMurtry, in his remarks concerning the treatment of cervicitis, caught my meaning exactly, so it will, perhaps, be well to state it over: If he will recall the paper, I stated that after you had treated in an active and vigorous way the subacute symptoms of gonorrhea with douche and with an iodoform pencil in the urethra; if, after all that, you found that the gonorrhea or vaginitis continued, an examination in that case would likely discover a cervical catarrh. After you have used the douche thoroughly for a length of time sufficient to cure, after you have used the iodoform plug in the cervix in order to favor drainage, then to cure the cervical catarrh which keeps up the specific vaginitis I favor as the third stage of treatment a vigorous attack upon that cervical mucous membrane. My observation in the treatment of gonorrhea, quite extensive, I may say, because I have had opportunities for six or seven years in the clinic at the University of Louisville to see a great many cases of cervical catarrh, leads me to believe, from the class of patients presenting, that they were generally gonorrheal in origin, and that ordinary treatment did them very little good. I am thoroughly conscious of the fact that it is dangerous to invade the uterine cavity unless it be urgently demanded. I am equally certain that cases of cervical catarrh of the kind I have just mentioned did not yield to vaginal treatment, and am pretty well satisfied that a thorough destruction of the cervical mucous membrane, which, as you know, is studded with follicles, is necessary almost in every case to effect a cure.

Now, with proper precautions, I believe that curetting can be done

without danger of further infection. I think the woman is in more danger of infection from extension of the disease to the higher cavities, the womb, tubes, etc., by allowing the catarrh to remain, or by temporizing with it by medicated washes, etc., than if you under the proper precautions use the sharp curette. I have seen such good results from the use of the sharp curette in the cervix (in fact, I do not remember ever to have seen a bad result) that I am inclined to advocate this treatment for the relief of all cases of obstinate cervical catarrh, by this means getting rid of the disease with the destruction of the mucous membrane.

Dr. J. M. Krim: Do you make any application to the surface after curetting?

Dr. Cecil: I do not believe any application is necessary. Further, I do not think any curetting short of the destruction of Naboth's glands will cure the case, as gonorrhea may lurk in these glands, and nothing short of their complete destruction will have a permanent effect. However, it is not a bad plan to follow curettage with a caustic like nitrate of silver.

Dr. Krim: By doing this it would certainly seal the raw surface, and prevent any further infection from gonorrhea. I think in these cases plain hot water for douchings without any bichloride will do just as well. I have used bichloride solution of strength 1 to 10,000 for gonorrhea in the male with no bad effects as far as the injections were concerned, but I never found that this treatment was any more successful than plain hot water.

T. C. EVANS, M. D., *Secretary.*

Stated Meeting, February 21, 1893, Dr. J. M. Krim, Vice-President, in the chair.

Dr. W. O. Roberts: (Carcinoma of the Mammæ.) The patient from whom this specimen was removed is sixty-seven years of age. Four years ago she had a growth that came on the end of her tongue, which she said when first noticed was as large as a pin's head. It steadily increased in size. One year after its appearance it was removed, and was then about the size of the first joint of her little finger. It bled very freely at times. Since its removal there has never been any appearance of the trouble about the tongue.

The growth which I have here was first noticed in the breast last fall a year ago; it was then about as large as an almond; it has steadily

increased in size up to the present time, and there is marked retraction of the nipple. The patient's father died of cancer, and two of her sisters have had operations performed for cancer. This tumor occurred without any history of injury whatever. She had, however, in earlier life some trouble with this same breast during the nursing of her children. I do not know how many children she has had, but with each of them she said she had more or less trouble with this breast, but never had an abscess. This case is very much like several others which I have had recently, where there have been several cases in each family of malignant disease.

The breast was entirely removed, of course, down to the pectoral muscle; the fascia was carefully dissected up, and the axilla thoroughly cleansed.

Last summer, just before the Congress of American Physicians and Surgeons, Dr. John Chiene, of Edinburgh, stopped over in Louisville, visiting Dr. Yandell, on his way to attend the Washington meeting, and he had with him an article from his assistant, Mr. H. J. Stiles, of Edinburgh, concerning the method of determining whether or not all the malignant growth has been removed in an operation for cancer of the breast. I thought possibly it would be of interest to the members of this Society if I would read an account of Mr. Stiles' method. The extract I have here is taken from the American Text-book of Surgery:

Mr. H. J. Stiles, of Edinburgh, has recently devised a method for detecting carcinomatous tissue, so that the surgeon at the time of the operation can ascertain whether he has removed all the carcinomatous tissue, or whether some portion still remains in the wound, and should be removed. His method is as follows:

1. Mark the position of the heart by a slight incision extending both on breast and on the skin which is to be left; this is to enable the operator to identify the position, and therefore the corresponding surfaces of the breast and the wound after removal of the breast.

2. Wash the breast in water to remove all traces of blood; this is important, because after treatment with nitric acid the blood becomes blackened and difficult to remove, and therefore greatly obscures the appearance which the acid brings out.

3. Submerge the whole organ in a five-per-cent aqueous solution of nitric acid (B. P.) for about ten minutes, that is to say during the time the surgeon is cleaning out the axilla.

4. Wash in plenty of running water for five minutes.

5. Place in methylated spirit (undiluted) for two or three minutes.

6. Examine the whole surface very carefully to ascertain (a) whether

any part of the tumor is exposed on the surface, or (b) whether any locally disseminated cancer foci are exposed on the cut surface, or (c) whether breast tissue is exposed.

The effect of the above given method is to render all carcinomatous tissue and parenchyma dull and opaque white through coagulation of the albumen of the protoplasm of the cancer and epithelial cells. The fibrous tissue of the stroma is rendered gelatinous, translucent, and homogenous in appearance, and somewhat india-rubber-like in consistence. The fact is unaltered. If any dull opaque spots of carcinoma appear on the under surface of the breast, more tissue must be removed at the corresponding point in the wound. This point is easily determined if the breast has been marked as directed. After examining the surface of the organ it should be cut in thick slices, which are to be treated in the same way; thus the various normal and pathological constituents of the mammæ can be readily and most satisfactorily studied. Cancer and parenchyma can be at once detected, if present, upon the cut surface, and since the examination can be easily completed before the time for suturing the wound; this method affords the surgeon a valuable aid in ascertaining the limits of the disease and of the organ.

DISCUSSION.

Dr. A. M. Vance: I would like to ask Dr. Roberts if he tried the method mentioned of detecting cancerous tissue in the case reported by him.

Dr. Roberts: I did not have an opportunity of trying it in this case. Mr. Chiene told me that his assistant was now using it in all his operations, and has great faith in it. I have a great deal of faith in Mr. Chiene, and the first opportunity I have shall try the method.

Dr. William Bailey: I do not know that such a thing would be possible, but it occurs to me if some method could be devised whereby an observation or test could be made of the surface left after removal of the tumor to determine whether any cancerous structure remained—if this could be done in some way without injury to the patient—I think it would be a better thing.

Dr. T. P. Satterwhite: I believe the general rule, whether malignant or not, is to give full scope to all tumors, especially if the growth be of a suspicious character, an abundance of healthy tissue being taken away.

I remember a few years ago a lady had a tumor, about the size of a hickory-nut, in the breast that gave her some discomfort and a little pain. I do not think her attention was called to it longer than a month before I removed it. I took the specimen to an eminent pathologist in

the city and asked him to make an examination and give me a positive opinion as to its character. He would not give me a positive opinion, and I took it to a second pathologist, who pronounced it carcinoma without any hesitancy, stating that it not only was cancer, but was an exceedingly malignant form. In removing that tumor I took out a quantity of healthy tissue, removing every thing down to the muscle. The wound had no sooner healed than the growth returned; it was again removed, the tumor being no larger than a filbert; in a short time it returned again, showing that the last physician's opinion was correct.

I had a talk with Prudden, of New York, who is considered one of the best and most reliable microscopists in the country, with a view of testing as to whether or not all of the diseased or malignant structure had been removed at the time of operation, and he told me there was no possible way it could be done; that you might have a microscope there while operation was going on to put a portion of the edges under observation, and yet it was an utter impossibility to tell. So I do not know how surgeons are to determine positively when they have removed all the diseased structure, unless the method mentioned by Dr. Roberts is a reliable way.

Dr. P. Gunterman: Pathologists claim that they can assist surgeons very materially at the time of the operation.

Dr. Bailey: I can conceive how the work would be very difficult, because the cells can not always be recognized under the microscope. It is only by the arrangement of cells that carcinoma can be detected, and this may not be easily determined in all cases.

I rose to mention a case. Three or four years ago a woman, between forty-five and fifty years of age, came under my observation with a tumor in the breast that gave her some concern, some pain; tumor not much larger than the end of my thumb. It remained there with but very little growth for a year's time. In the mean time the woman became subject of cancer of the rectum, and died from it, without further development of the cancer (which I believe it was) of the breast. The development of the growth in the breast was so slow, and gave her so little concern that no operation was ever performed for its removal. The fact that the patient died of cancer of the rectum is confirmatory evidence that my diagnosis of cancer of the breast was correct.

Dr. J. M. Krim: I simply wish to mention the case of a woman who has been operated upon three times for cancer, and is still in existence.

The first operation was twenty-three years ago, when the left breast was removed; two years afterward the right breast was removed, and I think it was a year later when the growth returned on the left side, just below where the breast was excised; this time the tumor was allowed to reach about the size of an orange, when it was carefully removed, and she has had no trouble since. Dr. Bayless at the time pronounced the structure malignant, and evidently it must have been; however, it has been fifteen years since the last growth was removed, and there is no evidence of a recurrence now.

Dr. Roberts: I have very little to say in closing. The only way is to continue to remove tissue until you fail to find evidence of carcinomatous structure. It strikes me that the method I have referred to is about as good as any. Of course it requires a man with some experience to carry on an examination during the time the operation is being performed, one, however, much less expert than would be required to use the microscope with frozen specimens. We endeavor, of course, in all cases to cut well beyond the diseased structures. There are some operators who make what is called a "cart-wheel incision," endeavoring to remove all diseased structures without any view whatever of approximating the surface afterward. There are some who remove all the tissue over the breast, go down and remove the greater part of the pectoral muscle, and then bring a flap up from behind to cover the breast; that is Halstead's method of operating. I think in all cases we should remove all suspicious tissue, and especially clean out the axilla. I believe this is of the utmost importance.

William Cheatham, M. D., read an essay on Paralysis of Laryngeal Muscles. [See p. 241.]

DISCUSSION.

Dr. Bailey: One point, that is whether or not obstructions or paralysees of the larynx are not characterized by inspiratory dyspnea instead of expiratory. I believe it is a fact that as a rule, as you go into a room where a patient is suffering with dyspnea, you can locate the site of the trouble by observation of the dyspnea. It is particularly characteristic that there is inspiratory trouble at the larynx, and expiratory trouble with other portions of the passage. We all know that a characteristic of emphysema is trouble in getting air out of the lung, difficulty in expiration. This is also true in obstructed respiration from other causes—if only one act is difficult, respiration is always slower than natural; if both acts are difficult, then respiration is hurried. But if

the obstruction is at the entrance of the larynx, or if it be emphysema, nature in a conservative manner prolongs the difficult act.

Dr. Roberts: I would like to ask Dr. Cheatham whether or not this tube his patient is wearing interferes with deglutition.

Dr. Wm. Cheatham: No; except for fluids.

Dr. A. M. Vance: (Spasmodic Stricture of the Esophagus.) I want to mention a case I saw once that always puzzled me. I was called by Dr. Clemens one night to see a little child, three years old, that could not swallow. I introduced a stomach-tube and put some milk into the child's stomach. I suggested that a trial be made with cocaine spray in the throat, and soon discovered that the child could swallow perfectly just after the cocaine was used. For a number of days each time the throat was sprayed with cocaine the child could swallow with comparative ease. It soon irritated the throat so that it became sore. The child afterward died of pneumonia. I have often wondered whether there was some form of paralysis preventing the child from swallowing, or whether there was some neurotic condition which the cocaine relieved temporarily.

Dr. Cheatham: I have no doubt the case reported by Dr. Vance was spasmodic stricture, which was relieved by the cocaine.

Referring to Dr. Bailey's remarks, I have seen several cases of this kind where the trouble was in expiration, though possibly, as a rule, the difficulty is in inspiration.

Dr. Roberts: (Case of Brain Syphilis.) I have a patient who is now forty-eight years of age. Twenty-five years ago he contracted syphilis. I saw him during the tertiary period of the disease, and he had very large and very extensive ulcerations of the soft structures of the extremities. I remember especially one upon the elbow-joint which involved the tendon of the triceps muscle. He had very large nodes on both tibia. He was under treatment with iodide of potassium, also some mercury, for something over a year, and all the symptoms disappeared. He went to a distant city and remained for several years, probably a period of ten years. He returned suffering from asthma; it was so bad that he had great difficulty in breathing, could not go up steps or take any exertion without getting entirely out of breath. Under iodide of potassium these symptoms entirely disappeared. There was no valvular disease of the heart, no evidence of urinary or kidney disease. He suffered at the time he had asthma from indigestion, and he still complains of that trouble. A year ago he had most terrific head-

aches, and I thought at the time they were possibly due to *grippe*. He was treated for that without benefit. Finally I put him on iodide of potassium, which gave entire relief. After quitting the iodide for a period of six months a node appeared on the forehead about as large as the first joint of my thumb. He was put back on iodide, and this passed away and left a depression which can be easily seen at some little distance. He has had no headache for some little time. A day or two after eating a hearty dinner, without any especial dyspeptic symptoms following at the time, he was taken with a well-marked attack of epilepsy, coming on by the jerking of one hand, finally shaking all over, then becoming unconscious, biting his tongue, frothing at the mouth, and all the symptoms of well-marked epilepsy.

Upon inquiry I found that years ago, while out west, he had a number of dizzy spells, but at no time lost consciousness, and within the last year he has had a number of these attacks, taking them to be simply vertigo from indigestion.

What I want to ask is whether or not this epileptic attack is the result of brain syphilis; whether epilepsy occurs in a person of that age except as a result of injury or structural disease of the brain.

DISCUSSION.

Dr. Satterwhite: I should infer from his having had these severe symptoms of tertiary syphilis that the present trouble is due to that cause.

Dr. Bailey: There are several interesting things in this connection, and I want to say this much in regard to the asthmatic attack: The relief by iodide of potassium of the asthma does not prove the syphilitic origin of the case, because iodide of potassium is the best known treatment for asthma. It will relieve more cases than almost any thing else. I do not believe as a rule epilepsy occurs in a person of this age, but this man may have been subject of *petit mal* without knowing what it was.

I remember seeing a case, with which Dr. Roberts is familiar, which I will mention in this connection. One evening, after having eaten an enormous dinner, a man over fifty years of age had two attacks that were very much like epilepsy. He had no recurrence, and I thought the safety to him was by virtue of his age, and that perhaps it was brought on by disturbed circulation from overeating. He had been in bad health for months, and had not at that time very fully recovered.

This case goes to confirm my opinion that it is still very doubtful about the cure of syphilis. How are we to know if a man is cured of this disease, when a man has gone practically for years and years without any new history may come out again with decided manifestations of syphilis? We have by means of treatment with mercury and iodide of potassium brought it into subjection, so that for many years it may not manifest itself, but I have seen so many cases where, after ten, fifteen, and twenty years, symptoms develop again that I have a little doubt whether we can be very sure about the absolute cure. I think I saw two sisters die, neither of whom had any symptoms of syphilis for thirty years; both died apparently of brain syphilis. This disease is very difficult to eradicate, and we never know whether it has been done or not.

T. C. EVANS, M. D., *Secretary.*

Foreign Correspondence.

LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

A Memorial to Sir Richard Owen; Cholera Precautions in Germany; Miss Marsden and the Lepers; Water Filtration; Insanitary Schools; Chronic Albuminuria and its Prognosis; A Novel Suggestion; The Hunterian Oration; The Nurses' Co-operation Society, etc.

The Prince of Wales has consented to become chairman of the committee which has been formed to erect a memorial to the late Sir Richard Owen. It is stated that the life of the distinguished naturalist is about to be written by his grandson, the Rev. R. Owen.

The draft of the bill to enforce the immediate reporting to the police of any outbreak of an infectious disease in any part of the empire has been laid before the German Federal Council. Any failure to report an outbreak within twenty-four hours will entail imposition of a fine varying from 10s. to £7 10s., according to the merits of the case, or, in default, imprisonment for seven days. Imprisonment for a period not exceeding three years will be imposed on any one allowing clothing or carriages to be used again before they have been thoroughly disinfected, while imprisonment or a fine awaits any one who refuses to follow the prescriptions of the official doctor.

Miss Marsden, the heroine who has faced untold dangers in her journey through the trackless forests on horseback to Siberia in order to practically help the outcast lepers, has recently been giving graphic descriptions of her journey, and the miserable condition in which she found the lepers, before various London audiences. Miss Marsden is endeavoring to collect funds to build a hospital for these sufferers. She is a clear and forcible speaker in this cause.

Dr. Franklin, the well-known sanitary expert, has given further evidence to the London Water Commission showing the results of his investigations, and laid great stress upon the necessity of efficient and careful filtration for the removal of microbes, urging that the other companies should follow the example of the Grand Junction in carrying out a system of double filters. The Thames basin, in his opinion, was the best source of supply in Great Britain, and contained sufficient water of excellent quality to serve the metropolis for at least a century to come.

Four years ago public attention was called in the columns of the public press to the deplorably insanitary condition of certain London Board schools, and, as the result of the inquiry thus initiated, investigation has been made into the state of some of the existing buildings. Of the 365 schools built by the Board, 230 already examined have been declared faulty and unhealthy, and it has been found necessary to appoint a Sanitary Committee, which has recently held its first sitting, to deal with the reports which continue to be sent in. In nearly all cases the Board paid for work which was not carried out, and consequently, in order to make bad drainage good, the rate payers of London are called upon to pay a further sum of £250,000.

In a discussion at the last meeting of the Medical Society of London on the clinical features of chronic albuminuria, with especial reference to prognosis, Dr. Lauder Brunton commented upon the great difference of opinion that prevailed as to the importance, from a life assurance point of view, of intermittent albuminuria. He thought that although some observers attached little importance to this condition, inquiry proved the fact that the health almost always underwent marked deterioration in the course of a few years, and he felt that albuminuria, even if intermittent, should preclude assurance except at a premium. He especially drew attention to the fact that the presence of albumen in persons over middle age was of the greatest importance. Dr. Brunton particularly mentioned the pathological importance of the variety of albuminuria in which, with a low specific gravity, the quantity of albumen present was so small as only to be perceived with the greatest care. Such cases indicated gout of the kidney, a form in which the disease might advance to such an extent as to threaten the life of the patient, though the slightest trace of albumen might be present in the urine. The treatment he suggested was non-nitrogenous diet and warmth, which, when carefully and properly carried out, would often prolong life for a number of years.

A curious suggestion was made at a meeting of the unemployed on Tower Hill. One of the speakers explained that medical students found it exceedingly difficult to procure "subjects" to experiment on anatomically, and the bones they were able to obtain cost so much that a complete framework represented about £10. It was therefore suggested that the unemployed, instead of marching to the Mansion House or to Parliament, should go in a body to the hospitals and sign contracts with the medical superintendents for the sale of their bodies after decease for the sum mentioned, on condition that £1 was advanced on the spot.

The Prince of Wales, who was accompanied by the Duke of York, honored the centenary of the death of John Hunter by attending the Hunterian Oration delivered in the theater of the Royal College of Surgeons by the president, Mr. Thomas Bryant. A large and distinguished company assembled to hear the address. Over the orator's desk was hung Sir Joshua Reynolds' portrait of the founder of scientific surgery, while on the table was placed the little bronze clock that belonged to Hunter, and which, as the president pointed out, still keeps good time. In the course of an eloquent eulogy on the work of the great surgeon the learned president, in the name of the fellows and members of the college, thanked the Prince of Wales and the Duke of York for their presence on the occasion. Subsequently their Royal Highnesses were conducted through the Museum by the president and Professor Stewart.

At the annual meeting of the committee of the Trained Nurses' Annuity Fund, the charity was confidently recommended to the public on the ground that no persons are more entitled to sympathy and support than broken-down nurses, who, having devoted their time and thoughts to the care of others and the alleviation of suffering, are left, when their own health fails, with no means of support.

The British Government having accepted the invitation of Austria to send delegates to a conference upon cholera precautions, to meet at Dresden, the Queen has appointed delegates to proceed there immediately. The delegates are Mr. Strachey, British Minister Resident at Dresden, Dr. Thorne Thorne, Chief of the Medical Department of the Local Government Board, and Mr. McFarnall, of the Foreign Office, who will act as Secretary.

The Nurses' Co-operation is an organization which has been founded to protect nurses who accept private work from what in other vocations is called "sweating," and to secure for them a better proportion of their earnings, often between two and three guineas a week, than the £20 to £25 a year grudgingly paid them by agencies and institutions. The average earnings of the 204 members of the Co-operation were £96 each last year, and a sum of £13,361, 10s. was paid to them net after deducting 7½ per cent.

Dr. Lowson, of Hull, has operated in a case of tuberculous disease of the lung by removing the right apex. The patient is at present progressing favorably.

Obstetrics and Gynecology.

In Charge of H. M. Goodman, M. D.

OBSTETRICAL DON'TS.—(For Beginners). 1. Don't indulge in the routine practice of administering ergot after every labor; only give it where there are indications of impending hemorrhage. 2. Don't give vaginal injections prior to the parturient act; it may do very well in hospital practice, but it is often the means of conveying infection in private practice. 3. Don't allow the mother or nurse to dictate your management of the case. 4. Don't use pads, cloths, or binders that have been used before, unless they have been thoroughly boiled and immersed in bichloride solution; it is better not to use them at all. 5. Don't leave your patient until all danger of *post-partum* hemorrhage is over. 6. Don't fail to have your hands, body, and clothing clean, and always thoroughly wash your hands and arms before touching the patient. 7. Don't allow your desire to save time cause you to use forceps. 8. Don't indulge in too frequent vaginal examinations. 9. After the completion of the third stage of labor don't touch the parts again so long as the patient continues to do well, save for cleanliness and removal of pads, and trust this to the nurse. 10. Don't fail to instruct the nurse to burn all cloths and pads immediately after removal from the patient. 11. Don't allow the nurse to use old pieces of linen, etc., as vulval pads, unless they have been previously boiled and soaked in bichloride and dried before being placed upon the patient; the best pads are made by inclosing a piece of absorbent cotton in bichloride gauze of proper size and fastening to the binder behind and in front by means of safety pins; wood-wool pads are also very good. 12. Don't use chloroform except when necessary to allay the severity of the pains, or where forceps are indicated; it should then be given to complete anesthesia; its use always increases the danger of *post-partum* hemorrhage.

ACARDIACUS AMORPHUS WITH A HEART.—“Heller (*Virchow's Archiv*, vol. cxxix, p. 3, September, 1892,) reports a case of this rare monstrosity. The mother was seventeen years old. She was a primipara, and was delivered of a healthy heart, and the acardiac was attached to the heart. There was no evidence of limbs, and no thorax nor abdomen. There was a trace of hairy scalp, and inside was a piece of bone. There were no intestines, but evidence of liver tissue. The pharynx, esophagus, and stomach were represented by a sac-like cavity. There was also a small piece of fat, with several cavities lying against the esophagus, which Heller considers as representing the heart.”

A GIGANTIC DEAD-BORN FETUS.—“Dr. F. Ortega (*Nouv. Archives d'Obstetrique*) reports a case of a primipara whose abdomen was so large that he was led to make a diagnosis of twin pregnancy. The child, which

had been dead for some time, weighed $22\frac{1}{2}$ pounds. The head was badly deformed. The length of body was 28 inches, and the width from one acromion to another $7\frac{3}{4}$ inches. The mother weighed 231 pounds."

A MEDICAL STUDENT during the recent examinations being asked the question, "What is the reaction of amniotic fluid?" scratched his head, began to look rather serious, and finally stated that "really he had forgotten the reaction, it had been so long since he had tasted it."

DR. W. F. McNUTT (Medical and Surgical Reporter, January 21, 1893,) reports five cases of uterine cancer in which vaginal hysterectomy was performed with successful result. One patient was in excellent health nine months after the operation.

SCHOFF (*Weiner Klinische Wochenschrift*) describes a case of removal of the uterus *per vaginam* for the relief of cancer limited to the fundus. The organ being very large, it was found necessary to incise the vulva for its removal. Several months after the operation cancerous nodules were found in the line of the incision in the vulva, while the adjacent parts of the vagina remained free from disease. Five months later the patient died, and cancer of the left lobe of the liver was discovered. The conclusion forced upon the reporter is that the incisions in the vulva were infected at the time of operation either by the instruments or the cancerous mass.

A CASE of considerable interest, occurring in the practice of the writer, is as follows: Mrs. X came to my office last April stating that she had missed her sickness and was suffering from nausea and vomiting. Physical examination showed some softening of the cervix, which was high up in the pelvis and pushed over to the left. This was due to a solid tumor of the ovary on the right side about the size of a man's fist. A diagnosis of pregnancy in the third month was made, and the following three propositions were made to the patient and her husband: (1) Shall we allow the pregnancy to proceed, watching case from time to time? If the tumor goes above the womb, allow the pregnancy to go to full term; if the tumor is caught between the sacrum and womb, then the induction of abortion. (2) Immediate ovariectomy, allowing pregnancy to proceed to term. (3) Immediate induction of abortion.

The patient, after consultation with two other physicians, decided upon the first course. At the beginning of the sixth month the tumor was low down in the pelvis, between the sacrum and womb, and it was immovable. Realizing that if pregnancy was allowed to continue that there could be no hope of delivering her at term, the induction of abortion was decided upon. A Nelaton catheter properly sterilized and a knot tied into the end was with difficulty inserted into the womb. This was owing to the high position of the cervix. In four days labor pains came on. The woman delivered without much trouble. She made an uninterrupted recovery, and has now consented to have the tumor removed.

Abstracts and Selections.

FUNGI AS FOOD-STUFFS.—On Monday afternoon, in the theater of the Royal College of Surgeons, Prof. Charles Bagge Plowright, M. D., M.R.C.S., delivered a lecture on Fungi as Food-stuffs. In his introductory remarks he described the morphology of fungi, and alluded to references to poisonous and edible fungi in ancient literature; he mentioned Ovid, who speaks of the peasants gathering white fungi for food, this being probably a species of the common mushroom; he referred also to the well-known lines in Horace about the meadow mushroom, which Horace considered to be the best. Galen, he pointed out, did not regard fungi with much favor, since he spoke of them as yielding cold, clammy, noxious juices. Toward the end of the eighteenth century the accounts of them became more detailed, and the noxious species were discriminated more accurately from the non-poisonous kinds. Fungi were common in all parts of the world, but most abundant in the countries which enjoyed a temperate climate. As food-stuffs fungi had to be considered from the points of view of nutrition, of their palatability, and particularly of their digestibility. These varied exceedingly in different groups and subdivisions. For instance, the mushroom, though being palatable and esteemed a delicacy, had been found to be exceedingly prone to give rise to a series of symptoms which the term "an attack of indigestion" did not sufficiently describe. On the other hand, some fungi which were less nutrititious did not give rise to any discomfort. An important consideration was the preparation which these objects received before being cooked. Many wholesome and nutritious foods might be very poisonous in their natural condition, but rendered innocuous by treatment. The tapioca plant afforded a good illustration of this. In the south of Europe fungi were gathered, dried, and preserved in bags for consumption during the winter. Before being eaten they were soaked in water, which was thrown away, and this process was repeated several times before they were cooked. This treatment of course spoils the flavor of the mushrooms. Preliminary desiccation might lessen the virulence of the harmful species, but this process was exceedingly likely to favor decomposition. Two of the most poisonous species of fungi remained poisonous after several months' drying. In France, where mushrooms abounded, and where people gathered them in the forests as a staple article of diet, they seemed to gather all sorts of fungi haphazardly as they came. Before cooking them, however, and using them as food, the fungi were invariably washed and soaked in salt and water, which acted as a powerful solvent of albuminoids and other organic compounds. Some continental cooks treated fungi with boiling vinegar before cooking them, and

thus they were enabled to eat species which were otherwise uneatable. By this treatment fungi lost their aroma and a good deal of their soluble nutritive properties.

Dr. Plowright then dealt with the chemistry of the subject at some length. This showed that fungi were of very varied chemical composition, containing generally a large quantity of water and varying proportions of albuminoids and saccharine materials. He then gave an interesting account of the common mushroom and the mode of distinguishing it from poisonous fungi. He spoke of its distinctive odor and the solidity of its stem as being points which assisted in making the diagnosis. Then the cuticle could be separated from the pilus. Unfortunately the most poisonous fungus which grew in this country, and which resembled the mushroom most closely, had also got a separate cuticle. All mushrooms should have the remains of the veil about half way down the stem, and the stem should be cylindrical and solid; it was always well to avoid mushrooms which from any cause had hollow stems. There were undoubted instances in which the true mushroom had produced symptoms of poisoning—diarrhea, vomiting, and a certain amount of collapse—due, no doubt, to a condition of incipient decay which rendered fungi very dangerous. The next point to note was the color of the gills. These varied very considerably. The gills were always pink in young mushrooms, always black in old ones; and between the two were found all shades of chocolate brown. In speaking of the varieties of mushrooms the lecturer mentioned the meadow mushroom of Horace as being the best. It was never very large, it had a beautiful pink color, and the surface of it was white and smooth, but not glossy. He also spoke of the horse mushroom as an exceedingly good species, but it should be avoided when too large. One peculiarity of this mushroom was that it assumed a yellowish hue on being bruised or rubbed with salt. The lecture was listened to by a considerable audience, and was evidently much appreciated.—*London Lancet*.

THE BACTERIOLOGY OF ACUTE PLEURISY.—It has already been generally accepted that purulent pleural effusions are occasioned by micro-organisms, and the view that a large proportion of the serous collections are tuberculous is rapidly gaining ground. Landouzy in 1883 stated that out of 100 cases of pleurisy usually ascribed to chill, 98 were in reality secondary to tubercle. This, however, has been looked upon as an exaggerated estimate, and one of the recent is that of Netter, who puts it down as 68.5 per cent. With regard to the presence of other organisms, fewer data are at hand. Fraenkel and others have demonstrated the presence of cocci in serous exudations before they have become purulent, but their occurrence in fluid collections that remain serous has been found in only a few cases. One of the most recent investigations (that of Levy) covered 37 cases of serous pleurisy; two, after typhus, etc., ultimately terminating in absorption, showed the staphylococcus pyogenes albus. The conclusion come to

was, that in the greater majority of cases of serous pleurisy the fluid was free from microbes, and that the presence of the staphylococcus pyogenes in serous collections was no guarantee that the fluid would become purulent, for it is possible for absorption to take place without further change. Goldscheider recently examined three cases of apparently simple pleurisy, and found that although none of them proceeded to empyema, streptococci, and in one case staphylococci, were isolated. The former showed in their behavior, by culture and in animals, no distinction from the streptococcus pyogenes and those present in empyema. From this it would appear that, pathogenetically and clinically, the difference in the virulence of one and the same streptococcus is more important than that of the species itself. It shows, moreover, that streptococci are not necessary for suppuration. Other observations have pointed to the conclusion that pus production does not result from the specific action of the microbe alone, but that other conditions, partly in the germ itself and partly in the organism, play a part. Hermann, one of Pasteur's pupils, found that it required five hundred million staphylococci to induce a subcutaneous abscess in a rabbit, and that the different tissues possess a varying power of resistance. It was possible in Goldscheider's cases that the number or the virulence was not sufficiently great. Respecting the origin of the micro-organisms, in one case Goldscheider supposed that they spread from the abdominal cavity, where an inflammatory affection existed, through the diaphragm into the pleura. In a second case it was evidently secondary to influenza, while the third might be looked upon as a primary infection, although the existence of a pneumonic focus could not be excluded. It is possible that many of the so-called rheumatic pleurisies are caused by streptococci, but this view ought to be received with caution, as the primary character has not been proved in any case with certainty.—*Zeits. f. Klin. Medicin.*

HUNTINGDON'S CHOREA.—At the eighteenth annual meeting of the American Neurological Association Dr. L. C. Gray, of New York, presented a man suffering from hereditary chorea. The disease had manifested itself in the same family for many generations. The movements had appeared in this case at the age of forty-five years. Dr. Gray then showed a case in a child which he considered was one of congenital Huntingdon's chorea. There had been no similar trouble in other members of the child's family, and the general history was negative. The choreic movements had been noticed immediately after birth. The infant was a seven months' child. It was the youngest case on record known to the speaker. During the discussion Dr. Sinkler said that Dr. Stephens, of Blackville, had reported several cases of hereditary chorea. The cases all belonged to one family, in which there had been this form of chorea for generations. The president presented a case of hereditary chorea in a man in whose family the disease had appeared for four or five generations.—*Journal of Nervous and Mental Diseases.*

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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KENTUCKY STATE MEDICAL SOCIETY.

It is not necessary to inform the profession of Kentucky that the State Society will meet at the State capital during the second week in May. Below we present a letter from the able Secretary, Dr. Steele Bailey, which contains all requisite preliminary information. The Secretary's desire that the State capital meeting should be a "banner meeting" we trust will be seconded by every member of the Society. His remarks as to the desirability of largely increasing the membership we hope will be duly pondered, and that each member will do his utmost to swell the ranks by bringing new recruits with him to Frankfort. While the list of members is large, and largely representative of the profession in Kentucky, it is a lamentable fact that many physicians who could give force and efficiency to the organization are still on the outside. To bring these in should be the worthy endeavor of every member now enrolled. The Frankfort meeting promises to be a big one and a good one. The programme will be rich, and the social features all that can be asked for. Let each and all do what in him lies to make it all that the Secretary would have it be.

Thus writes Dr. Steele Bailey:

The Kentucky State Medical Society will convene in the thirty-eighth annual session at Frankfort, Wednesday, May 10th, at 11 o'clock A. M., and will continue in session through Thursday and Friday.

Reports from the Committee of Arrangements, of which Dr. E. E. Hume, of Frankfort, is Chairman, point to a magnificent meeting at the capital city, socially and scientifically, and we trust that each member of the Society may make it convenient to be present.

As is well known, the Society is not a close corporation with completed membership, but desires to largely extend its usefulness and enlist in its ranks every one of the *regular* profession not already included in its membership. Those who are not members, and who wish to work for the good of the profession, we cordially invite to be present at Frankfort, May 10th, 11th, and 12th, and there present their applications for membership.

Our object is the cultivation and advancement of medical science and of medical literature, the elevation of the standard of professional education, and the promotion of the interests, honor, and efficiency of the medical profession throughout the State of Kentucky.

It is gratifying to state that the programme is filling rapidly. Those who want a place on it must notify the Secretary at once. We want to have it printed and in the hands of the members by the first day of May.

The Secretary announces with pleasure also that an excursion rate of one and one third fares for the round trip has been secured on all the roads in the State of Kentucky.

You are invited to attend the meeting. STEELE BAILEY, M. D., *Sec'y.*

CAUSES OF FAILURE IN THE TREATMENT OF APPENDICITIS.—Dr. E. Laplace read a paper on this subject before the Medical Society of the State of Pennsylvania. He said that while it is commonly accepted that the vermiform appendix is the structure primarily affected, recent literature still leaves one somewhat unsettled on the following points:

1. What are the conditions that imperil a case of appendicitis if left untreated?
2. What are the conditions that imperil a case if treated, (a) medically, (b) surgically?

He concluded his paper by the following statement: The main causes to which, in our judgment, failure should be ascribed are, (1) Tardiness in undertaking the medical treatment; (2) tardiness in undertaking the surgical treatment, should no improvement follow the first thirty-six hours' medical treatment; (3) granted surgical treatment, shock and improper drainage, especially when the case has been of more than three days' standing; (4) granted surgical treatment and that the case may be seen within the first seventy-six hours, the chances of failure at a minimum, because the mere opening of the abdominal cavity in these days of anti-septic surgery is attended with but very little risk.—*Medical News.*

Notes and Queries.

To the Editors of the American Practitioner and News:

THE SECTION ON THERAPEUTICS OF THE PAN-AMERICAN MEDICAL CONGRESS.—It is the earnest desire of the officers of the Section on Therapeutics of the Pan-American Medical Congress that both specialists and general practitioners should contribute articles to its proceedings. Gentlemen who desire to read papers at this meeting should notify the undersigned at once of their intention, and should send him by July 10th, at the latest, an abstract of their paper, in order that it may be translated into the three official languages of the Congress and published in the programme. The importance of this Section and the interesting papers which have already been promised give assurance of a very successful meeting.

PHILADELPHIA.

H. A. HARE, *President of Section.*

NEW BY-LAWS, PAN-AMERICAN MEDICAL CONGRESS, BY THE EXECUTIVE COMMITTEE, FEBRUARY 22, 1893.—*Languages:* By-law IX. Papers may be read in any language, providing that authors of the same shall furnish the Secretary-General with an abstract not exceeding six hundred words in length in either of the official languages (English, Spanish, French, or Portuguese) by not later than July 10, 1893, and providing further that a copy of each such paper shall be furnished in either of the official languages, at or before the time of the meeting, to the secretary of the section before which the same shall be read. Remarks upon papers may be made in any language, providing that members making such remarks shall furnish a copy of the same in either of the official languages before the adjournment of the session.

Publication: By-law X. All papers read either in full or by title shall be immediately submitted for publication in the Transactions (Special Regulation 3), but authors may retain copies and publish the same at their pleasure after the adjournment of the Congress.

Constituent Organizations: By-law XI. All medical, dental, and pharmaceutical organizations, the titles of which have been transmitted with approval to the Committee on Organization, or which may hereafter be transmitted with approval to the Executive Committee by any member of the International Executive Committee, each for his own country, shall be subject to election by the Executive Committee, approved by the President, as constituent bodies of the First Pan-American Medical Congress, and each organization thus constituted shall have the right to designate as delegates all of its members attending the Congress, but no such organization shall meet at the time and place of meeting of the Congress as a dis-

tinct body, providing that the secretary of each such constituent body shall furnish a list of officers and a statement of the number of members of his respective organization to the Secretary-General not later than sixty days before the meeting of the Congress, and shall forward a list of delegates chosen to reach the Secretary-General before the opening of the Congress.

PAN-AMERICAN CONGRESSIONAL BULLETIN.—*Section on Medical Pedagogics*: The Pedagogic Section will devote its attention especially to the history of the development of medical education in America. In the papers presented by leading teachers recent advances in methods of instruction will be considered. The art of teaching, which is regarded as a study of great interest in other branches of learning, has received hitherto but little attention from the medical profession. The Section in Medical Pedagogics will therefore be made a prominent feature of the Congress, and it is hoped that those interested in medical education will co-operate in the work of this section by being present and by actively engaging in the discussion of subjects presented. Any inquiries or communications may be made through the Secretaries, J. Collins Warren, M. D., Executive President, Boston, Mass.; Charles L. Scudder, M. D., English-speaking Secretary, Boston, Mass.; Wm. F. Hutchinson, M. D., Spanish-speaking Secretary, Providence, R. I.

THE following physicians have been appointed members of the Advisory Council of the Anatomical Section of the Pan-American Congress: Dr. F. Mall, University Chicago, Chicago; Dr. Charles F. Dolley, 3707 Woodland Avenue, Philadelphia; Dr. Edward K. Dunham, Carnegie Laboratory, New York; Dr. Elizabeth R. Bundy, Woman's Medical College, Philadelphia; Dr. Wm. M. Gray, Army Medical Museum, Washington; Dr. H. C. Tinkham, University Vermont, Burlington, Vt.

THE SECTION ON DERMATOLOGY AND SYPHILOGRAPHY of the Congress has been fully organized as follows: Honorary Presidents, Dr. Silva Aranjó, Rio de Janeiro, U. S. of Brazil; Dr. L. Duncan Bulkley, New York; Dr. Juan C. Castillo, Lima, Peru; Dr. Louis A. Duhring, Philadelphia; Dr. Le Grand N. Denslow, St. Paul; Dr. Maximiliano Golan, City of Mexico, Mexico; Dr. James Nevins Hyde, Chicago; Dr. Prince A. Morrow, New York; Dr. R. B. Morison, Baltimore; Dr. D. W. Montgomery, San Francisco; Dr. A. Ravogli, Cincinnati; Dr. A. R. Robinson, New York; Dr. Antonio Rubio, Pinar del Rio, Cuba; Dr. M. Lucas Sierra, Santiago, Chili; Dr. R. W. Taylor, New York; Dr. A. Van Harlinger, Philadelphia; Dr. J. C. White, Boston, Mass.; Dr. Edward Wigglesworth, Boston, Mass. Executive President, Dr. A. H. Ohmann-Dumesnil, No. 5 South Broadway, St. Louis, Mo. Secretaries, Dr. Wm. S. Gottheil (English-speaking), 25 West Fifty-third Street, New York City; Dr. John Forrest (Spanish-speaking), Charleston, S. C.; Dr. Carlos Lloveras (Piedad 944), Buenos Ayres, Argentin-

tine Republic; Dr. Viscarra Heredia, La Paz, Bolivia; Dr. W. S. Barnes (Leper Hospital), Mahaica, British Guiana; Dr. Joan P. Gabiza, Rio de Janeiro, U. S. of Brazil; Dr. J. E. Graham, Toronto, Canada; Dr. Enrique Robelin (Jesus Maria 91), Havana, Cuba; Dr. Daniel E. Coronado (Calle 13, num. 120), Bogota, Republic of Columbia; Dr. Daniel Nuñez, San Jose, Costa Rica; Dr. Angel Rivera Paz, Gautemala City, Gautemala; Dr. H. G. McGrew, Honolulu, Hawaii; Dr. Strachan, Kingston, Jamaica, W. I.; Dr. P. Numa Rat, Antigua, Leeward Islands, W. I.; Dr. Francisco Bernaldez (Escuela de Medicina), City of Mexico, Mexico; Dr. Bevan N. Rake, Port of Spain, Trinidad, W. I.; Dr. Manuel Bonasso (Arapey Esquina Colonia), Montevideo, Uruguay; Dr. Adolfo Briceño Picón, Merida, Venezuela. Advisory Council, Dr. T. B. Keher, 911 Chestnut Street, St. Louis; Dr. E. B. Browson, 123 West Thirty-fourth Street, New York; Dr. Jos. Zeisler, 125 State Street, Room 27, Chicago; Dr. J. P. Knoche, Kansas City, Mo.; Dr. W. T. Corlett, 333 Prospect Street, Cleveland, O.; Dr. M. P. Vander Horck, Syndicate Block, Minneapolis; Dr. B. Merrill Rickets, 137 Broadway, Cincinnati, O.; Dr. H. W. Blanc, Sewanee, Tenn.; Dr. J. V. Shoemaker, 1519 Walnut Street, Philadelphia; Dr. J. H. Bloom, Louisville, Ky.; Dr. H. W. Stelwagon, 1411 Spruce Street, Philadelphia; Dr. J. C. McGuire, Washington, D. C. Communications, notices of papers, etc., should be sent to the Secretary, Dr. W. S. Gottheil, 25 West Fifty-third Street, New York City.

THIS unique assemblage promises to be one of the most important events that has occurred in the history of medicine in the Americas. Its success is assured by the large number of valuable papers already promised. The Section on General Medicine, which is one of the most important that has been created, bids fair to be one of the most successful in the entire Congress, and already many valuable contributions are in process of preparation, and will be read at the meeting in September. It is hoped, with the hearty co-operation of all physicians living not only in North, but also in South and Central America, that the work in this Section will be memorable, and each physician living on this continent is requested to join this most important Section and to prepare a contribution to be read before that body. It is especially requested that those intending to join this Section or to read papers shall at once send their names, with titles of papers, to the Secretary, Dr. Judson Daland, No. 319 South Eighteenth Street, Philadelphia, Pa., so that they may be noted on the calendar and given their appropriate places.

THE SECTION ON LARYNGOLOGY AND RHINOLOGY of the Pan-American Medical Congress is now thoroughly organized with Secretaries in all the countries of South America as well as in the United States and Canada. The President, Dr. E. Fletcher Ingals, of Chicago, is making a thorough canvass to secure a large number of good papers for the Section, and, aided as he will be by the able Secretaries, Drs. Murray and J. Maron y

Alonso, and the corps of honorary Presidents, he feels assured of the success of this department of the Congress. The honorary Presidents are, Dr. Harrison Allen, Philadelphia; Dr. Franke H. Bosworth, New York; Dr. J. Solis Cqhen, Philadelphia; Dr. D. Bryson Delavan, New York; Dr. J. F. Dixon, Portland, Oregon; Dr. Stephen Dodge, Halifax, Nova Scotia; Dr. W. C. Glasgow, St. Louis; Dr. Frederick I. Knight, Boston; Dr. Geo. M. Lefferts, New York; Dr. Alvaro Ledan, Villa Clara, Cuba; Dr. John N. Mackenzie, Baltimore; Dr. David Matto, Lima, Peru; Dr. P. Emelio Petit, Santiago, Chili; Dr. John O. Roe, Rochester, N. Y.; Dr. Federico Semel-eder, City of Mexico, Mexico; Dr. Chas. E. Sajous, Paris, France. The Secretaries for Foreign Countries are, Dr. Ovejero [Piedad 22], Buenos Ayres, Argentine Republic; Dr. H. Guedes de Mello, Rio de Janeiro, U. S. of Brazil; Dr. G. W. Major, Montreal, Canada; Dr. Felix Campuzano [Virtudes 33], Havana, Cuba; Dr. Luis Fonnegra [Calle 10, Numero 263], Bogota, Republic of Columbia; Dr. Fabricio Uribe, Guatemala City, Guatemala; Dr. Henri Goulden McGrew, Honolulu, Hawaii; Dr. Angel Gavino [Cocheros 15], City of Mexico, Mexico; Dr. J. Midence, Leon, Nicaragua; Dr. Eugenios Cassanello [San José 119], Montevideo, Uruguay; Dr. Napoleón F. Cordero, Merida, Venezuela. All physicians interested in this Section are requested to correspond with the Secretaries for the United States. Dr. J. Maron y Alonzo (Spanish-speaking), Las Vegas, N. M. Dr. T. Morris Murray (English-speaking), Washington, D. C.

Special Notices.

Physicians are always interested in any new and reliable pharmaceuticals that are placed on the market. Among the latest novelties in elegantly manufactured preparations we would call your attention to Planten's "PERLOIDS" or Improved Pearl Shaped Capsules, of which we have just received samples.

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We call the attention of our readers to the advertisement of the Robinson-Pettet Co., Louisville, Ky., which will be found on another page of this issue. This house was established fifty years ago, and enjoys a widespread reputation as manufacturers of high character. We do not hesitate to endorse their preparations as being all they claim for them.

THE AMERICAN PRACTITIONER AND NEWS

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Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

ALOPECIA.

A Clinical Lecture Delivered at the Medico-Chirurgical Hospital of Philadelphia.

BY JOHN V. SHOEMAKER, A. M., M. D.

Professor of Materia Medica, Therapeutics, and Clinical Professor of Skin and Venereal Diseases in the Medico-Chirurgical College of Philadelphia.

GENTLEMEN: It is scarcely necessary to bring before you a collection of bald pates. Every one is familiar with the bare and shining poll. Such cases are their own demonstration. You have all likewise observed the gradual thinning of the locks, ending in more or less complete baldness. I have, however, two patients to exhibit this morning. The first man is not bald, his hair has not as yet appreciably thinned, but he presents a diseased condition of the scalp which, unless thoroughly cured, will infallibly lead to loss of hair. The second patient is a good example of a special form of partial baldness termed alopecia circumscripta.

If you look around you in any public assemblage you can not fail to observe the numerous bald heads—I mean in men comparatively young—and you are likely to ask yourselves, why is loss of hair so common? Are there no means of preventing the misfortune? Why are men so much more frequently attacked than women? An hour may be profitably spent in replying to these queries, and, above all, to the second.

What is the cause of baldness; say, rather, what are the causes? In the first place we may divide the affection into three groups or varieties, senile, premature, and circumscribed. Of the first I shall say but

little. In the declining stage of life the hair becomes gray and falls. These are among the changes incidental to old age, and individuals usually accept their fate with resignation. It is an entirely different matter when a man of twenty-five or thirty perceives that he is losing hair. Scarcely an individual will receive this knowledge with complacency. It is much to be regretted that the victims usually waste their time by following the recommendations of some self-appointed adviser, or trusting the sage counsels of the barber with his "dandruff cures," soaps, and "hair tonics." Of alopecia circumscripta I will speak subsequently.

The causes of premature baldness may be either systemic or local. Whatever influence or combination of influences depresses the vitality of the hair follicles depresses *pari passu* the nutrition of the hair roots which spring from those follicles. If the capillary circulation or the nerve influence of the hair-beds is deficient the vigor of the hair must be impaired. Projecting into the bottom of the hair follicle, like a little bud, is the hair papilla. It is chiefly through this papilla, which contains two arteries and some medullated nerve fibers, that the hair is nourished, though the walls of the follicle, to a certain extent, also minister to the life of the hair.

Many systemic conditions affecting the quality of the blood, the vigor of the capillary circulation, and the influence of trophic nerves lead to premature loss of hair. Not infrequently a weakness of the hair-forming apparatus is inherited, and in certain families most of the male members, a few years after attaining manhood, begin to notice thinning of the hair. This lowered nutrition of the scalp may and often does coexist with notable vigor of the digestive and muscular systems. It is the soft and silky hair which earliest perishes. Curiously enough the victims of early baldness are almost invariably abundantly supplied with hair on other portions of the body: they have strong beards, hairy breasts, arms, and legs.

Apart from a hereditary tendency, habits which waste nerve force have much to do with the production of early baldness. These customs depend partly upon the exigencies of life in modern centers of population and partly to the self-indulgence born of wealth and luxury. The foundation of the trouble is often laid in the school-room. It is lamentably too much the practice, especially in the public schools of our great cities, to place an inordinate amount of work upon the child. Those who are gifted and ambitious injure their health: the nervous

system is weakened, the circulation is enfeebled, dyspeptic difficulties arise, and sleep is disturbed. These factors are very apt to result in early baldness. Loss of hair is much more common among professional students than artisans. In adult life the anxieties, competitions, and responsibilities from which few can escape have an injurious effect on the nutrition of the hair. The excessive use of coffee, tea, alcoholic drinks, and tobacco has the same effect. Excessive stimulation of the genital organs is another source of early baldness. Many severe diseases occasion a fall of the hair. Even in children we not infrequently see the scalp more or less denuded as a consequence of scarlet fever. The hair often suffers, becomes dry, thin, or falls out after an attack of typhoid fever. Erysipelas, typhus, and cerebro-spinal fever may produce the same result. The puerperal state sometimes occasions more or less thinning of the hair. Alopecia is a common manifestation of secondary syphilis, either dependent upon the quality of the blood or caused by lesions upon the scalp. In acute baldness due to serious constitutional disease the hair generally grows again when the health is completely restored. This is true even of syphilis.

I now call your attention to the first patient. He is twenty-seven years of age, a carpenter by occupation. He has never suffered from any serious illness, is well built, apparently well nourished, but informs me that he is troubled considerably by indigestion. This is probably the remote origin of the disease of the scalp. He states that he has endeavored to pay proper attention to the care of his hair. He has been in the habit, especially since he has noticed the condition of the scalp, of having a wet shampoo every week. Once in two weeks is quite often enough to have this tonsorial operation performed. A too frequent use of soap and water is injurious to the skin and hair. Remember, also, that the scalp may be damaged by too vigorous manipulation with the brush and comb. As this man approaches you will at once perceive that the collar and shoulders of his coat are covered with yellowish-white scales which have fallen from his head. Upon looking at his scalp and separating the hairs, you will observe that the surface is covered with dry, greasy, dirty-looking scales. In some places they are adherent, while in others they are loosened and ready to be shed. When detached the scalp is somewhat hyperemic. This is not always the case. Sometimes the skin is normal in color, and again it may even be paler than usual. This person's hair has a dull and lusterless appearance. He is annoyed by itching of the scalp. The scales consist of

a vitiated and dried sebaceous material mixed with proliferated epithelium.

This is a sufficiently well-marked case of what is usually known as seborrhea sicca. This affection is the most frequent cause of premature baldness. Its evil influence upon the nutrition of the hair is immediate and local, although it is interesting to note how general and local causes co-operate; for the seborrhea itself is, as a rule, dependent upon some deviation from perfect health. It may be due to anemia, chlorosis; it may follow fever, or, as in the present case, may be the result of gastrointestinal derangement. Seborrhea is, if left unchecked, an extremely chronic affection. It lasts for years. The products of disease occlude the glands of the scalp, compress the hair follicles, and eventually cause atrophy of the hair papilla. The hair follicles are finally sealed up by the organization of new fibrous tissue. The subcutaneous fibrous tissue is thickened while the corium undergoes an atrophy which may reduce it to two thirds or even one half of its normal thickness. The fibrous elements of the skin are thickened but its muscular tissue is diminished. The sebaceous glands, at first enlarged, are finally atrophied. The sudoriparous glands, on the other hand, are enlarged, and this circumstance may explain the profuse perspiration of the scalp to which bald people are subject.

Hyperidrosis of the scalp, I may incidentally remark, often precedes baldness. While these anatomical changes are slowly progressing the hair must inevitably suffer. The hairs are, if I may be allowed the expression, *squeezed out* of existence. As their beds fill up they become shorter and thinner until, the follicles being obliterated, they can no longer be reproduced. Baldness of this kind is necessarily permanent. There is not the faintest hope of a cure. We can, however, generally arrest the march of the disease. How important, therefore, it is to begin the treatment at an early stage.

The case of the man now before us offers a favorable prognosis. Though there is a large amount of crusting the hair seems to be firmly implanted. He states that when he brushes his hair a shower of scales falls off, but that the hairs are not loosened. I do not detect any evidence of thinning. Our task must be, therefore, the removal of morbid products and the restoration of the sebaceous glandular system to healthy action.

I shall not have time in this lecture to do much more than allude to seborrheic eczema, which, according to the teachings of Unna, really

includes most if not all the cases heretofore denominated seborrhea sicca. However this may be, a change of name, or even of our conceptions of the pathology of the disease, can have no effect upon its clinical features. Suffice it to say at present, that in seborrheic eczema we have a fine desquamation, followed in course of time by the formation of large, fatty crusts, and finally the escape of an oily fluid which dries into yellowish crusts. The hairs are loosened in their beds, entangled in the crusts, and come away when these are removed. Seborrheic eczema is thought to be of parasitic origin.

Other diseases of the scalp may produce baldness. Among these I may mention lupus vulgaris and lupus erythematosus, tinea favosa, herpes zoster, and pityriasis rubra. Eczema does not give rise to alopecia except in those rare cases where abscesses result. The loss of hair then corresponds to the area in which loss of tissue had taken place.

Let us now direct our observation to the second patient. This is also a male, twenty-three years of age, a baker. You see that he has on the left side of the head a bare spot, nearly round in shape and about the size of a silver dollar. Upon the vertex is another patch of about equal size. There is, in other words, baldness in circumscribed patches or area. Hence the name of the malady, alopecia circumscripta or areata. The bare patches are rather paler than the normal skin. A few unhealthy hairs spring from their surface. I find that the hairs around the margin of the patches can be easily plucked. There has been no itching. A peculiarity of the case (and this is characteristic of alopecia circumscripta) is that the baldness appeared abruptly. He went to bed one night about two weeks ago with a full head of hair, and the next morning, when about to use his brush, discovered to his astonishment a bare spot on the side of the head. Five days later, with equal suddenness, the spot appeared upon the top of the head. The patches have not enlarged. They were as large at first as they are now. This is the general history of alopecia circumscripta. When patches are large, numerous, and coalesce, the baldness may involve nearly or quite the entire scalp. In such instances it can only be distinguished from ordinary alopecia by the different history. Circumscribed baldness may occur at any age. It is often associated with disease of the nervous system, as neuralgia or epilepsy, or develops from sudden shocks or frights. It may follow any severe disease. Our patient informs me that he has but lately recovered from a severe attack of typhoid fever. Certain cases of this kind are thought to be due to the action of a para-

site, though an organism has not yet been discovered. At all events, it sometimes seems to be contagious in schools, hospitals, and barracks.

It is now in order to speak of the treatment of alopecia. From what I have already said you will anticipate that the treatment must be directed to its underlying cause, which, in most cases of premature variety, is dry seborrhea. Before approaching the purely medical management, however, I wish to say something concerning the proper care of the hair as a prophylactic measure.

For its healthy growth hair requires ventilation and sunlight. The custom of keeping the head so constantly covered has to answer for much baldness among men. Women are indebted for their comparative immunity to the fact that much of the time their heads are free from hat or bonnet, and that they bestow much more time and attention to the toilet of the hair. Soft, light, and perforated hats are less injurious than stiff silk hats. The sparing use of an animal oil is beneficial. Once or twice a week the head should be thoroughly cleansed with soap and warm water, avoiding an excess of soap. The comb should have coarse, smooth, and large teeth. If a fine-tooth comb must be sometimes used to remove fine scales or dirt, it should not scratch the integument, but simply be drawn through the hair. Rough brushing is also injurious. Hair-dyes are detrimental. The dry shampoo assists in maintaining the health of the hair. The wet shampoo is beneficial if not too frequently repeated. Singeing promotes nutrition of the hair which has suffered in consequence of fever.

And now as regards medical treatment. Endeavor first to discover the exciting cause. Strive to correct any disorder of stomach, bowels, liver, or nervous system which may exist. Insist upon the regulation of faulty habits of life. I am not referring to cases due to syphilis, which demand appropriate specific treatment. If the general health is much impaired the individual must be placed upon a generous diet. A change of climate is advisable in such cases. Tonic drugs are of value, such as iron, quinine, strychnine, hoang nan, phosphorus, coca, cantharides, and kola nut. Cod-liver oil and arsenic are serviceable in some cases. Pilocarpin sometimes has a notable effect in stimulating the growth of the hair. It may be given by the mouth every other night at bed-time in $\frac{1}{12}$ to $\frac{1}{6}$ grain or more, but the hypodermic injection of $\frac{1}{3}$ grain once or twice a week answers a better purpose.

As our first patient is troubled with indigestion, I shall order him to take hoang nan. This remedy is of double utility. It stimulates

secretion of the digestive fluids, and it has a special influence upon the sebaceous glands. It may be combined as follows :

- R Extracti hoang nan fluidi, f. ʒiss ;
 Extracti chiratæ, fluidi, f. ʒss ;
 Acidi hydrochlorici diluti, f. ʒijss ;
 Aquæ menthæ piperitæ, q. s., ad. f. ʒij.
 M. Sig: Teaspoonful in water three times a day.

In cases which are associated with anemia we should administer preparations of iron, manganese, arsenic, or chlorate of potassium. Sulphur is another excellent constitutional remedy. It is a normal constituent of hair and essential to its nutrition. Sulphur is beneficial in seborrhea sicca when given in 5-grain doses thrice daily and for a considerable period.

Although general treatment has its place, local therapy can not be neglected. In a case like the one before us the first indication is to clear the scalp of scales in order that our remedies may come into contact with the diseased surface. Scales are most easily removed by means of an oil freely applied. When the scales are large and thick the parts should be saturated. A cap of flannel or oiled silk prevents the application from greasing clothing or other objects. Olive, linseed, or almond oil are useful, but the oil of ergot is still more beneficial. Its mildly stimulant properties prolong its effect after the scales have been detached. If necessary it may be diluted with olive oil. I am also fond of mixing a small quantity of the oil of eucalyptus with the oil of ergot. A mixture of the last mentioned substance with an equal part of fluid oleate of mercury, oleic acid, glycerine, or a fifty-per-cent solution of boro-glyceride can also be recommended. If the surface is found red after the scales have been removed, only mild applications are permissible. If the skin is pale more active agents can be employed. A hard soap containing camomile or sulphur cleanses the scalp and moderates the morbid process. An emulsion of yolk of egg with lime-water answers the same purpose. An infusion of quillaya or soap-bark is still more efficacious.

In order to improve the nutrition of the hairs we make use of stimulant applications, the strength of which must depend upon the stage and gravity of the case. When any doubt exists we should begin with mild preparations. Among the articles which may be employed are table-salt, carbonate of potassium, glycerine and water, carbolic acid,

Peruvian balsam, corrosive sublimate, resorcin, naphthol, and oleate of zinc. Tar, sulphur, or the iodide of sulphur in the form of ointment, are also advantageous. Ten grains of tannic acid to an ounce of glycerine is an efficient preparation. The use of jaborandi externally has proved of service. It may be used by mixing $\frac{1}{2}$ dram of the tincture with equal parts of glycerin and lanolin, and rubbing a small quantity of the preparation upon the head every night. Corrosive sublimate is used in the strength of 2 to 5 grains to the ounce of water or fat. A mixture of equal parts of glycerine and alcohol or cologne-water is of service. In cases requiring or permitting more decided stimulation we may employ alcoholic preparations, ether, turpentine, solution of ammonia, white precipitate ointment, chloral hydrate, mercurous oleate, thymol, chrysarobin, etc. In obstinate cases we may resort to veratrine ointment, tincture of cantharides, mustard, capsicum, or croton oil. Massage is a useful procedure.

One of the best methods of stimulating the glands and follicles of the scalp is by the application of galvanism or faradism. The interrupted current should, in the beginning, not exceed 3 or 4 milliamperes, applied by means of moistened sponge electrodes. I am much in the habit of using faradism passed through a brush with metallic bristles, the moistened sponge electrode being held by the patient. In the present case I shall order :

R Sodii boratis, 3j;
 Balsami Peruviani, 3j;
 Glycerini, f. 3j;
 Lanolini, 3j.

M. A little of this preparation is to be rubbed into the scalp night and morning after the crusts have been removed.

Circumscribed alopecia requires treatment adapted to the constitutional condition of the patient and the cause of the affection. General and local galvanism is an excellent method of treatment. As the patient before us has not fully recovered his strength after an exhausting disease, I shall put him upon the following mixture :

R Acidi phosphorici diluti, f. 3iij;
 Tincturæ ferri chloridi, f. 3iij;
 Syrupi simplici, q. s., ad. f. 3iv.

M. Sig: Teaspoonful in water thrice daily.

As a local application in this case we shall make use of the ointment of the mercurous oleate. When the patches are pale active stimulation

is usually necessary. Ointments containing naphthol, thymol, sulphur, iodide of sulphur, cantharides, chrysarobin, turpentine, tannic acid, or veratrine are efficacious. Shaving the patches has frequently a beneficial effect, and singeing the hairs when they begin to be reproduced is also of utility. Sometimes it is necessary to use a blistering fluid, such as the tincture of cantharides, $\frac{1}{2}$ dram to the ounce of alcohol. Small but rebellious patches may be painted once a week or ten days with cantharidal collodion. Large spots do not allow such heroic measures. As this patient is young the ultimate prognosis is good, though treatment will probably be demanded for a considerable period.

WHAT IS THE SPHERE OF THE NASAL SPRAY?*

BY T. C. EVANS, M. D.

In a recent discussion on this subject before the American Laryngological Association Dr. Frank Bosworth, of New York, said: "I have recently removed the air-pump and spray apparatus from my office, and I believe I have done better work since than when I placed much dependence upon them." I am not yet ready to adopt such an extreme course as indicated by Dr. Bosworth. I find my spray a convenient method of cleansing the nasal cavities in atrophic rhinitis, in some cases of nasal syphilis, and occasionally in the purulent diseases of the accessory sinuses. But aside from these I do not think sprays accomplish any good. When we take into consideration its indiscriminate use, I am convinced that rhinology in general and our patients in particular would be much better off if every man doing work in this line would follow the example of Dr. Bosworth. I believe that few men now claim to be able to remove genuine hypertrophies or deviations by local medication, but we all know that it is still a matter of common experience to see patients suffering from purely anatomical obstructions of the nose, who have been astringed, stimulated, disinfected, resolved, oiled, and anointed according to the particular fancy of the individual member of the professional gauntlet which he has been so patiently running.

The treatment of diseased nasal mucous membrane by astringent and detergent sprays is such a pleasing, plausible kind of a placebo,

*Read before the Louisville Clinical Society, March 7, 1893. For discussion see p. 292.

has such a wonderfully potent moral effect on the patient, and has associated with it so many hopes and traditions that many practitioners still cling to its use, knowing full well that their practice is not borne out either by theory or clinical facts.

For the first year and a half after I began to devote special attention to diseases of the nasal cavities I was so situated as to have abundant opportunities for observing the course of these affections under the use of medicated sprays both in private and dispensary practice. I mention this simply to emphasize the fact that my skepticism in regard to this method of treatment is not born of prejudice, nor is it the product of any preconceived theory or notion, but is the legitimate child of disappointment. In spite of all my zeal and faith, after spraying my patients in season and out of season, I was quite forcibly impressed with the fact that all cases of nasal obstruction that came under my observation were almost hopelessly chronic, in fact the only limit set upon the time of treatment was the limit of the patient's perseverance.

Two years ago I read a paper before the Kentucky State Medical Society on "The Indiscriminate Use of the Nasal Spray," in which I endeavored to show the uselessness of this routine method of spraying, as well as to call attention to its pernicious effects by depriving the patient of the relief that might be afforded by the more rational and radical methods of nasal surgery. In concluding that paper I said: "Taking it all in all, about the most charitable thing that can be said of the nasal spray is that it rarely does harm, even in the hands of the inexperienced."

Now, after a more extended experience, I wish to reiterate what I then said in regard to the inefficiency of medicated sprays in the treatment of the obstructive diseases of the nose, and to modify that part of my concluding remarks in which I said "they rarely do harm." All astringents, whether vegetable or mineral, sprayed into the anterior nares act as irritants, the degree of irritation depending upon the strength and temperature of the solution, the condition of the mucous membrane and the idiosyncrasy of the patient, but always acting as irritants in a greater or less degree. The alkaline sprays are perhaps less irritating; still I think it may be safely said that the spraying of any cold, watery solution into the anterior nares is injurious. I mean injurious, of course, in a limited sense, and do not wish to be understood as saying their use is followed by any very grave or marked symptoms, for experience has taught us that the nasal mucous membrane is an exceedingly hardy

structure, that it endures the vicissitudes of climate, the vices of civilization as well as the blunders of medical science, if not uncomplainingly at least with a degree of toleration that shows it to be endowed with remarkable powers of resistance. The use of sprays in cases of acute coryza prolongs and intensifies the attack. In chronic rhinitis they complicate matters by engrafting upon it an acute attack. They always make the patient exceedingly uncomfortable during and for some hours after treatment. The substitution of vaseline and other petroleum products as a menstruum has done much to mitigate the evils of the aqueous solutions. First, because they are of themselves non-irritating; secondly, because they decrease or nullify the action of the drugs applied to the mucous membrane; but their use is open to serious objections aside from the fact that they are therapeutically inert. They arrest or at least greatly impair the respiratory functions of the nose by forming an impervious coating to its entire mucous surface; they prevent the giving off of heat; they prevent the exhalation of moisture; they prevent the exchange of gases that should normally take place in the nasal cavities. In short, this protecting of the nasal mucous membrane with vaseline, of which we have heard so much, simply means that we abolish the respiratory functions as long or often as we apply protection, so that the inspired air, instead of reaching the larynx and lungs saturated with moisture and raised to a temperature approximating that of the blood, is cold and dry as in buccal respiration. It is admitted even by their most zealous advocates that their prolonged use produces a condition very closely resembling atrophic rhinitis.

The history of nasal therapeutics shows that sometimes at least there is much in a name. The older writers, laboring under a misapprehension both as to the anatomical structure and the function of the nose, classed all disorders of this organ under the general name of "catarrh." To this name and not to any existing pathological condition was due the general introduction and great reputation of medicated sprays.

It must be admitted that the spray is a most ingenious apparatus; that it affords a speedy, efficient, and cleanly method of applying medicines to the whole of the nasal mucous membranes; but, unfortunately for all concerned, we have not in the whole pharmacopeia a single medicine (cocaine perhaps excepted) of which we can say with any degree of assurance that when so applied it will favorably influence either the course or duration of any of the obstructive diseases of the nasal cavities.

To sum it up briefly, I will say that the sphere of the nasal spray is an exceedingly limited one; that, with the medicaments as commonly recommended in text-books, its use in most conditions of the nose is positively detrimental; that there are a few conditions where we find it convenient for cleansing purposes; that it is never curative; that those morbid conditions of the nasal passages which are amenable to treatment, are such as can be corrected or relieved by surgical means.

LOUISVILLE.

Reports of Societies.

THE LOUISVILLE CLINICAL SOCIETY.*

Stated Meeting, March 7, 1893, Dr. I. N. Bloom, President, in the chair.

The essay of the evening was read by Dr. T. C. Evans; subject, What is the Sphere of the Nasal Spray? [See p. 289.]

DISCUSSION.

Dr. Wm. Cheatham: I agree with nearly every thing the essayist has said concerning the use of the spray in the treatment of nasal affections. However, I have not been able to dispense with it, especially in home practice, for the reason that I have never found any thing to take its place. As a substitute in some cases I use the post-nasal syringe, but find very few patients who can use such an instrument on themselves. Again, I use the "feeding cup" as a douche for cleansing purposes after any surgery of the interior of the nose. The objection to the spray, in the first place, is that it is not thorough. When used anteriorly it will not reach one half of the internal surface of the nose. Neither will the douche when used anteriorly. The internal anatomy of the nose is such that no medication used anteriorly reaches thoroughly all parts, so the only thorough way to treat the nose is from behind forward, whether spray, douche, or syringe is used.

In the treatment of laryngitis, for the spray I have substituted the brush and the syringe. In atrophic rhinitis I scarcely ever use the spray, using the syringe.

*Stenographically reported by C. C. Mapes.

Dr. Coomes (visiting): I have listened with a great deal of interest to Dr. Evans' paper, and much of what he has said I think is correct. But certainly the atomizer is an instrument that can not be dispensed with, particularly, as Dr. Cheatham says, in home practice. No doubt there are many of these cases that would be better treated by surgical interference, first washing out carefully with either posterior or anterior nasal syringe, as it is now positively known that there are many diseases affecting the nasal cavities that we can not cure in any other way. Still I can not agree that the atomizer is simply a placebo. It is an instrument for the purpose of carrying medicated fluids into the nose. The question of whether the nasal cavities can be thoroughly medicated by its use is of course a debatable one. In other words, if the atomizer is properly directed high up into the nares, all parts of the tissue will be reached. Of course, with the atomizer we can not flood the nasal cavities, as can be done with the ordinary syringe. I do not think the atomizer should be attacked *because it is an atomizer*. There are other instruments used as a means of conveying fluids to the nasal cavities for the purpose of medication that are no more effective as curative agents. I recognize the fact that there are numerous cases which I treated fifteen years ago, that I thought could be cured with the atomizer, that I know now were not and can not be cured by this means. I know that nothing short of instrumental interference will ever cure them. There are other cases of atrophic rhinitis, for instance, where the parts are dry, and I know of nothing in the world that will so effectually moisten them as the atomizer. It is also valuable in cases of nose-bleed where there is a constant oozing. We often find cases where we can not pack the nostril, as patients will not tolerate it. I think the atomizer has been unduly assailed, and that Bosworth will be like a good many other men—will move it back into his office. As Dr. Cheatham says, very few patients can use a post-nasal syringe. It is a somewhat dangerous instrument, and if used by the patient is very liable to cause strangulation, and unless the pharynx is very well trained it is the exception for the post-nasal syringe to be tolerated.

The use of vaseline and grease in the nose as curative agents is simply absurd. Of course I can understand when a patient has had an exceedingly sensitive nose how a little medicated oil may be of benefit.

Dr. J. M. Ray: I am most freely in accord with the statements made by the essayist. Any one who will study the pathology of nose diseases I think will come to the conclusion that very little benefit is to be

derived from any form of medication by the spray or otherwise. I do not think in the paper Dr. Evans intended to attack the spray *per se*, but any form of medication to the nose, whether spray, syringe, douche, or otherwise. I do not think it is possible to cure any form of nose disease by the spray. It is of value as a cleansing agent, but not as a curative agent.

The first paper I had the honor of reading before a medical society in this city was on the subject of Chronic Nasal Diseases, and I made the statement at that time that what we needed was more throat surgery and less throat doctoring. The longer I live the more I have reason to reiterate that statement. I believe that all cases of obstructive rhinitis require for their relief some form of surgical procedure. I do not think that any case of hypertrophic rhinitis could ever be cured by the spray. The disease is not in the mucous membrane. There is no interference with the secretions from the mucous membrane. The cases of so-called excessive secretion from the nose are simply the result of defective drainage. The secretions accumulate because of hypertrophy, and the secretions liberated all at once appear as an enormous quantity within a short time.

I simply want to emphasize the fact that I do not believe any form of nasal medication applied in solution ever cured any case of chronic nose disease, whether applied by the atomizer, douche, or any thing of the kind. We are often forced to wash out the nose, and as a cleansing agent I know of nothing better than the spray used anteriorly and posteriorly.

With reference to the use of oils in cases of acute rhinitis, I believe there are cases in which the application of neutral oils sometimes acts as a soothing application and is agreeable to the patient. Whether it cuts short the attack or not, I am unable to say. I heard a doctor friend remark that he had been suffering for a week from an acute attack of rhinitis, and was advised by a number of professional friends to use various forms of medication, every one of which had done harm. He said that he believed there was no form of local application that would cure a case of acute rhinitis. I am much of the same opinion. Take acute rhinitis, and the more you wash it out, especially with any form of aqueous solution, the more irritable becomes the mucous membrane; the more blood we draw to the part, the more sensitive becomes the mucous membrane.

Dr. S. G. Dabney: In the main I agree with what Dr. Evans has

said. The spray, in my judgment, is not of much value as a curative agent except, perhaps, in acute cases, where it seems to have a pleasant, soothing effect. I hardly see how we can entirely dispense with the atomizer, not only in atrophic rhinitis, but also in the hypertrophic form. Most modern pathologists now claim that hypertrophic rhinitis is due to some form of obstructive process, and with each inspiration there is more or less vacuum created just back of the obstruction, the air not passing readily from before backward, being hindered by this obstruction, the partial vacuum so created causing distension of the blood-vessels and consequent hypertrophy. Granting that this pathology be true, the treatment indicated would be a removal of the cause, and that means to remove the obstruction. I have very little to say upon the subject, as I believe the ground has been very fully covered. The spray has been greatly abused in the past, because relied on as a curative agent, but I do not believe that we will dispense with it entirely in the future, as for cleansing purposes and especially for use at home it is valuable.

Dr. T. P. Satterwhite: I have used the atomizer for some years, but have never seen a nasal cavity thoroughly cleansed by any form of spray. I do not suppose the quantity of liquid thrown into the nose at any time would amount to over a dram or two in the form of spray. Where there is obstruction of the secretions I have always used the douche, but not to have any current to go through the nose with much force. This is the only means with which I have been able to thoroughly cleanse the nasal cavity.

Dr. T. C. Evans: I really feel very much flattered that the gentlemen present have discussed the paper as thoroughly as has been done, and feel gratified that most of them agree with me. Perhaps Dr. Coomes did not properly understand me. I quoted from an article by Dr. Bosworth, but stated that I had not gone to the extreme of having the atomizer removed from my office. I have found the spray very useful for cleansing purposes, but in cases of chronic obstruction of the nose I can not see that it has done any good, and also have very serious doubts about acute attacks being cut short. I am sure they were not shortened any by use of aqueous solutions. I have seen a few cases that seemed to be made more comfortable and slightly benefited by cocaine early in the attack. I mentioned particularly in my paper that the most frequent form of medication to the nose was by application of the spray. What is true of the spray will also apply

to other forms of nasal medication. I meant to say that all forms of local medication in the obstructive diseases of the nose are worse than useless.

Dr. Cheatham: (Stricture of the Tear Duct.) I have recently had three cases of stricture of the tear duct, which I want to mention. The first case, a young woman has an obstruction of the tear duct with an abscess of the sac. What I want especially to refer to is, in two of the cases after inserting the probe I made an examination of the nose, which I have not done very much until recently, and found that the probe, instead of entering the inferior meatus, had penetrated along between the mucous membrane and the turbinated bone into the middle meatus. Almost no force or violence was used in making this false passage.

Another case, child five years of age. I had treated this patient for stricture of the tear duct for four or five months. She had also been treated by several other physicians without relief. I had examined the nose several times, and saw no special obstruction there. The tear duct seemed to be perfectly formed, and there was evidently no stricture; still drainage could not be induced. Upon closer examination I discovered that the turbinated bone was pressed too close to the wing of the nose. Taking a strong pair of forceps and inserting them between the side of the nose and the turbinated bone, with very little effort I lifted it in proper position, and the child has had no further trouble. The whole difficulty was that the turbinated bone had grown too close to the side of the nose, closing the passage. In correcting the position of the bone I relieved the child after it had been treated at least eight or nine months.

I want to make a point that it is very important to examine the nose in these cases, especially after you have used the probe to see whether it has made a false passage, as it did in the two cases mentioned, and to see if there is any obstruction in the nose at the lower end of the duct.

DISCUSSION.

Dr. Ray: It has been my experience that treatment of obstructions of the lachrymal apparatus is, as a rule, very unsatisfactory. I have tried nearly all forms of treatment that have been devised, and the more I treat this trouble the more chary I become about slitting up the puncta and canaliculus. I believe if you slit up the puncta and canaliculi you destroy capillary attraction and do away with the muscular contraction in the circular muscular fibers in the walls of the can-

aliculi, and then all drainage that takes place from the eye must be simply gross drainage. I always make it a point to examine the nose in these cases. Sometimes I have been able to discover the probe in the nose; in others have been unable to find it. I am treating a case now of chronic obstruction in the lachrymo-nasal duct. I can pass a probe through the duct into what I presume is the nose, and the nose will bleed; then looking into the nose I am unable to find the probe. I put cocaine into the nose, contracting the turbinated body, and passed the probe to see if I could feel it. I was able to get the metallic click, but could not see it.

I believe if you once start in with these cases the best thing to do is to open up the duct well into the sac, and thus get gross drainage; further, that the best way to do this is to take the lachrymal knife and slit well into the sac, then pass it into the nose and cut the stricture, then turn the knife and bring it out, to be sure that the stricture is cut, then by continued passage of the probe afterward see that it is kept open. There is no doubt that a great many of these cases are accompanied by nose disease, hypertrophy, or thickening of the turbinated bodies; therefore I am in the habit of examining the nose to see if the turbinated bone is not misplaced in any way. I believe that the few cases that I have seen completely cured have been cured in the manner above described.

Dr. Coomes: I never tell a patient that comes to me with obstruction of the nasal duct that relief can be assured in any given time. It may be six months, six years, or they may get relief in one month. I think in the majority of these cases the trouble will be found to be stricture, and it is absolutely necessary to secure thorough drainage. Occasionally I have found stricture in two or three places. Like Dr. Ray, I have run across obstinate cases where I have failed to get relief, notwithstanding the fact that I have slit up the canaliculus, upper and lower, making a free opening. I think this is the best method of treatment, as in that way we get free drainage.

Dr. Cheatham: My idea in reporting the two cases was to show how easily a false passage might be made, the probe just slipping along between the mucous membrane and inside the turbinated bone, no more force being used than when the probe passes through the natural opening. I believe the latest authorities agree that the tears are not carried by capillary attraction at all. If stricture exists in the nasal duct, I think it should be located just as would be done in the urethra.

Suppose you have a stricture in the upper part of the tear duct, what is the use of running a knife through into the nose? With a stricture in the upper part of the tear duct I fail to see the occasion for using the knife. It seems to me the proper thing to do would be to use the probe and dilate it thoroughly.

Dr. W. H. Wathen: (Rupture of Gall Bladder; Death.) Several times recently the question of appendicitis has been discussed in this Society, and particularly the methods of diagnosing it with sufficient accuracy to justify operation. Cases have been reported in which the symptoms plainly indicated appendicitis, where after-results showed that the peritonitis and death were the result of other causes. I refer particularly to a case reported by Dr. Dugan. The symptoms of appendicular trouble were apparently nearly pathognomonic, but when the operation was performed the appendix was not diseased, and the gall-bladder, filled with gall-stones, had ruptured.

Last week I was telegraphed to be present at the *post-mortem* upon a distinguished physician in the State of Indiana, who had died from some form of abdominal trouble. This gentleman had consulted me, and I had examined him upon a number of occasions. About two years ago he had a little jaundice (which I never knew until after his death), but all the symptoms he had ever complained of, and about which he had consulted me, were referred particularly to the region of the appendix, midway between the anterior superior spinous process of the ilium and the umbilicus. He complained of no trouble in the region of the liver, and his symptoms so plainly indicated appendicitis that I incidentally mentioned that possibly if he had any recurrence an exploratory laparotomy should be performed, which would at least reveal the true nature of his trouble. He had such a horror of operations that he would not entertain the idea. About ten days ago, while away from his home in a distant State, he was taken suddenly ill with severe pain in the same region complained of before. He grew rapidly worse, and died within three days. Six or eight hours before his death the physicians in attendance thought he was improving, but he suddenly grew worse and died. In the *post-mortem* I believed we would find the appendix not only diseased, but that it had caused an abscess to burst into the peritoneal cavity, resulting in suppurative peritonitis. When an opening was made in the mesial line great quantities of pus came out. I presume in all there must have been a half gallon. The entire peritoneum was intensely inflamed, and in some places ulcer-

ated, the mesentery particularly. The doctor making the *post-mortem* searched at once for the appendix, but found no enlargement in that region, no indurations, no intestines matted together. Finally, pulling up the appendix, it was found to be inflamed, just as was all other parts of the peritoneal cavity. Finding nothing in the intestines, nothing in the appendix, nothing in the kidneys that would account for the peritonitis, he examined in the region of the liver, which he found not enlarged, but the gall-bladder was collapsed. No concretion could be felt in the gall-bladder, but quite a number of gall-stones were found in the peritoneal cavity, showing that death resulted from rupture of the gall-bladder. Probably gall-stones had caused inflammation, suppuration, and rupture.

I report the case to show how difficult it is to make in some cases a correct diagnosis in intra-abdominal diseases. It is well to report cases of this kind, as they are often more instructive than those where we operate and find we were correct in our diagnosis. While we can usually diagnosticate pathological conditions in the abdomen with sufficient accuracy to justify operation, we seldom can come to any thing like an accurate conclusion as to the conditions with which we will be compelled to deal when we have opened the abdomen.

Dr. A. M. Vance: I assisted Dr. Dugan in an operation for supposed appendicitis where a condition similar to that mentioned by Dr. Wathen was found. In this case I suppose gall-stones to the amount of several hundred were removed from the cavity. It was found that the gall-bladder and not the appendix was the organ diseased. The man recovered from this operation, though he was *in extremis* at the time. The gall-bladder was found located in the region of the appendix, and the incision made over this region came immediately down upon the gall-bladder, which was ruptured, causing localized peritonitis. The patient lived for six weeks after the operation, and died of pneumonia. A *post-mortem* was held, and a great many gall-stones were found in the remains of the gall-bladder.

I believe if the patient referred to by Dr. Wathen had been operated upon at the beginning of the last attack his life might possibly have been saved.

Dr. J. M. Krim: (Case of Syphilis and Typhoid Fever.) Six weeks ago I was called to see a case that has been under treatment for secondary syphilis, having all the symptoms usually present in such cases. I found the patient suffering from an attack of typhoid fever, and four

weeks after he came under my observation the eruption existing prior to the development of typhoid fever entirely disappeared. The enlarged glands grew smaller, and he has now in the sixth week not a symptom of the secondary condition existing. He was not under treatment more than ten days for secondary syphilis, and certainly the treatment he received in this time could not have been sufficient to cause disappearance of the syphilitic symptoms. I simply want to ask the members if they have ever seen a case where the eruption disappeared in this way, and whether it will return again.

DISCUSSION.

Dr. I. N. Bloom: It is not unusual for eruptions to disappear during an acute disease, and as a rule recur after the acute disease has passed off. In this case, however, the eruption had already lasted three weeks, which is as long a time as it usually remains. The most interesting feature is the disappearance of the enlarged glands. I never give medicines in cases of syphilis until the secondary symptoms are manifest. I have known syphilides to disappear in three or four days before medicines given could possibly have had any effect. Then again I have seen papular and pustular syphilides last two, four, and five weeks and longer under rigid treatment.

Dr. Vance: (Lateral Dislocation of Elbow; Child, aged Nine Years.) I would like to mention a case of dislocation of the elbow-joint in a girl nine years of age, the second case of lateral dislocation of the elbow I have ever seen where the ulna and radius were carried entirely outside of the humerus, reduction being very difficult. In the first case, which was a patient about the same age, treatment was instituted for fracture, and reduction was never brought about. In the last case referred to, I believe the difficulty was from interference of the biceps tendon, it in some way preventing the bones remaining in position after they were replaced by great force. I finally, however, reduced it, and the subsequent history is that the whole arm was greatly swollen, and the child has suffered a great deal from the traumatism due undoubtedly to the efforts at reduction. It is the second case I have ever seen, and I believe that dislocation laterally of the elbow is very rare. There was no fracture in this case.

Dr. Evans: (Epileptic Seizure during Tonsillotomy.) About two weeks ago I operated on a patient, removing a very small piece of tonsil. I applied with a cotton carrier a small quantity of four-per-cent

solution of cocaine, and proceeded to pull the tonsil up with forceps and clip off the piece with a pair of scissors. The patient did not seem to suffer any pain, and there were no symptoms of syncope. Without any evidence of being sick, no whiteness around the mouth, he simply dropped out of the chair, and would have fallen on the floor had I not caught him. I laid him out on the floor, thinking that it was simply a case of fainting, but he had a very distinct convulsion, and I proceeded as quickly as possible to get some whisky. By the time I had gotten the whisky to him he had regained consciousness. The point that struck me was that it might be a case of cocaine poisoning. As he recovered so quickly, I concluded that this could hardly be the case, and inquired into his previous history. I asked him first if he had ever had a fainting spell before, and he told me that he had, and seemed rather disgusted with himself that he should have gotten sick in my office. I inquired into the history a little further, and learned that on one occasion he had been sitting in a chair reading and had one of these attacks, simply falling out of his chair on the floor, so I concluded that I had just happened to operate at the time he had one of these epileptic seizures.

DISCUSSION.

Dr. Cheatham: I think Dr. Evans' conclusion of epileptic seizure is probably the correct one.

Dr. Vance: My experience is that people often topple out of the operating chair without any cocaine, without any thing except a minor surgical procedure. I had a patient faint to-day while the instruments were being prepared for a minor operation. I can recall several cases where fainting has followed the introduction of the hypodermic syringe, there being no history of epilepsy or any thing of that kind. However, in Dr. Evans' case the history points very strongly to the fact that it was epilepsy.

Dr. Coomes: I have seen several cases of cocaine poisoning, and my observation is that it sometimes takes a very little cocaine to produce a decided impression.

Dr. Wathen: I do not think in Dr. Evans' case the amount of cocaine given could possibly have had any thing to do with the trouble, and it seems from the history that the patient was in the habit of having such spells. If a sufficient amount of cocaine were administered to affect a person to that extent, the effect would be more lasting, because it can not be so easily eliminated from the sys-

tem. I have had no trouble of this character in my own experience, because I do not use cocaine. I am impressed with the fact that the greatest danger from the use of cocaine is where it is used upon a cut surface. I believe you can put upon the mucous membrane a quantity that would not manifest any poisonous effect; with half the quantity on a cut surface you might have serious poisonous effects from it.

Dr. Cheatham: I think Dr. Wathen is wrong. If I am not mistaken the mucous membrane absorbs cocaine much more rapidly than does a cut surface. I prefer not giving whisky to a great many of my patients, so as a substitute give capsule of valerianic ether. This combination is good for nervous females, and counteracts any danger from cocaine.

Dr. Vance: I believe that a great many of the men who have written upon the subject agree that cocaine when used about the head has a much more powerful effect than anywhere else. My experience is that this product is absorbed more rapidly by the mucous membranes than it will be when applied to cut surfaces. When a tourniquet can be used I believe that cocaine can be employed *ad libitum*, but in other cases it is sometimes attended with considerable danger. I remember using in one case, where operation was done for an epulis of the upper jaw, 29 grains of cocaine in solution, the operation lasting nearly four hours. I believe the reason this patient did not die of cocaine poisoning was that the blood was continually washing it away. This is the greatest amount of cocaine I have ever used in one case. For a number of years I employed a four-per-cent solution, but now use a six-per-cent. In the case referred to, where such an enormous quantity was used, the patient absolutely refused to take chloroform, owing to her having been operated upon some years previously in Virginia, and coming near dying from the effect of the anesthetic. She recovered from the operation, and now wears artificial teeth, the excrescence never having returned.

I have had no trouble in the use of cocaine since the first few months' experience, invariably giving whisky beforehand.

T. C. EVANS, M. D., *Secretary.*

LOUISVILLE SURGICAL SOCIETY.*

Stated Meeting, March 13, 1893, Dr. W. L. Rodman, President pro-tem, in the chair.

Dr. A. M. Vance: (Perforative Shot Wound of Abdomen; Operation; Recovery.) The seventh day of last February this patient, thirty years of age, was shot with a 32-caliber bullet in the left side of the abdomen, five inches to the left and on a line with the umbilicus. I saw him within a very short time, probably about a half hour afterward. He showed evidence of very marked shock, evidence of being greatly impressed, and I had him removed carefully to the Norton Infirmary, opened the abdomen quickly as I could, and found two complete perforations of the ileum—two of entrance, two of exit, also one of the mesenteric border of the ileum. Suturing was rapidly practiced, and he was gotten off the table really in better condition than when he went on. A glass drainage-tube was left in the lower angle of the external wound for forty-eight hours; drainage was very considerable. The man has made a rapid and very satisfactory recovery. He was walking about the infirmary at the end of the second week; has lost very little strength or flesh. On the fourteenth day he was given a purgative. For five days he was starved to allow rest of the alimentary tract. The lower bowel was emptied by enematas; he has not had an untoward symptom, and is about well now.

DISCUSSION.

Dr. W. L. Rodman: How long after the shot before the bowels were allowed to act?

Dr. Vance: I think I relieved the bowels by enemata at the end of forty-eight hours, just for comfort.

Dr. W. C. Dugan: How long after taking food was he shot?

Dr. Vance: I do not know, but he had probably been eating considerable, because he vomited on the table an enormous quantity, and the intestines were filled with feces.

Dr. Dugan: Was there any fecal matter in the cavity?

Dr. Vance: I could find none in the cavity; it was very thoroughly washed out, in fact the major portion of the time consumed in operation was in irrigation, getting rid of material vomited, and reading of the intestines. I used the continued Lembert suture of catgut supported by resuturing, the ends of suture being tied together.

I think it is very important in these cases of section, especially in men, that a bandage should be worn for a long time to support the cicatrix. I think hernias are more likely to take place after laparotomy in men than in women. This may be accounted for by the greater convexity of the abdomen, and consequent increased strain.

Dr. H. A. Grant: What was the temperature after operation?

Dr. Vance: I do not believe the temperature was ever over 100° F. The pulse ranged along about 90 for the first week, then came down to normal. He was starved absolutely for three days; for a number of days more he only received consomme, and for several days following he was only given eggs. I have come to the conclusion that egg raw is the best thing that can be given after operations of this character.

Dr. George W. Griffiths: I think Dr. Vance is to be congratulated upon the very marvelous result of the case; it would have been a necessarily fatal one, I should say, without operation. I operated upon a case of the kind two or three years ago, where there were several perforations of the intestine; in this case there was a concealed hemorrhage about the spinal region which could not be controlled, and the man died thirty-six hours after operation.

Dr. Dugan: Certainly Dr. Vance is to be congratulated upon the results obtained in this case. I am rather surprised that these cases have always been fatal. You will remember two papers in the New York Medical Journal by Stimson, where he reported up to that time all the cases he had been able to get the history of in America. In this valuable contribution he compared the results of those cases operated upon with those left without operation, and the conclusion of this painstaking surgeon was in favor of non-operation. The mortality, I think, in the cases operated upon was 87 per cent, and the cases that were left and treated purely by the expectant plan 83 per cent. He concluded his discussion, however, in his last report by stating that, while the mortality was in favor of the non-operative procedure, he would, under favorable surroundings, operate even in the face of such evidence. That, coming from Stimson, a conservative man, yet a bold surgeon, I think should not be passed over lightly.

Now, in regard to the late war—while we are not to be governed by statistics compiled in those pre-antiseptic days, they have been referred to in previous discussions—so I take the liberty of calling attention to this here as they have some bearing on the subject, since they show the result of the non-operative treatment: Otis states that there is no case

on record of gunshot wound of the small intestines that recovered. In gunshot wounds of the stomach there were a number of cases on record of recovery, and of the large intestine under 80 per cent terminated favorably. I have two cases of gunshot wounds of the intestines to report, and they were both fatal. They were both cases of perforative wounds, and both patients died in condition of shock. Certainly the case reported by Dr. Vance is one of extreme interest, and the reason of this happy result is that he operated at once before extravasation of fecal matter into the peritoneal cavity had taken place, and had his patient in an infirmary, thereby having the advantage of hospital service. I do not wish to be understood as standing here advocating "the let-alone plan" of treatment. I would have done exactly what Dr. Vance did. We are confronted by the startling fact that most all these cases die after operation. We can not promise the patient much. The mortality in Louisville has been, with Dr. Vance's case excepted, 100 per cent. In conclusion I wish to say, that all cases coming under observation soon after the injury, with favorable home or hospital surroundings, where the surgeon can command the services of good assistant and nurse, should be operated on—otherwise leave them alone.

Dr. Grant: It seems to me that in the present understanding of these cases, the light in which surgery has put them at the present day, such cases as those spoken of by Dr. Dugan and the one reported by Dr. Vance are understood by all surgeons to imperatively demand an exploratory incision even if there is a possibility that the intestine has not been perforated. I do not think the statistics Dr. Dugan refers to are of much value in the light of the present progress of surgery, and I think that conservatism would hardly be the term that would be applied to any surgeon who would hesitate to operate under conditions at all favorable, it would rather be cowardice. There can hardly be any question at the present day but the wisest plan is, if there is any doubt about there being perforative wounds, to explore through the wound itself with the finger until perforation is determined, and if that perforation is found to be in a favorable situation, enlarge the wound to a complete laparotomy, or complete the operation by making another incision in the median line, as Dr. Vance did. When there is any question as to perforation going through the abdominal wall, it is easily settled by exploration by the finger. Four or five years ago there was some question about the size of bullet and the point of perforation. A

small bullet penetrating the abdominal wall above the umbilicus was looked upon by some surgeons as not indicating an absolute necessity for operation. A larger bullet in any situation and all bullets penetrating below the umbilicus were marked by many surgeons, especially Wyeth, as demanding investigation by abdominal section. At the present day, however, I believe that the surgery of laparotomy has been rendered so safe, under such conditions as we are able to command in nearly every case, as to make it little less than criminal for a competent surgeon to hesitate to open the abdomen with a view of determining whether perforation of the intestine has occurred. Where perforation of the intestine has occurred by almost any bullet that is used by any weapon at the present day, the certainty of fecal extravasation is almost absolute. Where fecal extravasation has occurred a fatal result will almost invariably obtain. Where one of the larger vessels of the mesentery is divided, or important viscera wounded, fatal hemorrhage will be almost sure to result; and, if any thing should happen to control it, sepsis, even if there were no perforations of the intestine, would be a very imminent danger. I am thoroughly impressed with the belief that the danger of an exploratory operation is almost nothing, if it be properly conducted, in comparison to the immense risks that the patient is subject to without this operation. And I think it is hardly wise, and perhaps upon second thought Dr. Dugan will agree with me, to consider these old statistics in view of the present status of surgery.

With respect to the operative steps, it has been my preference in suturing all the viscera of the abdomen to use silk rather than catgut, because I believe it is more certainly rendered aseptic, it is easier handled, and very fine silk can be used, perhaps finer than catgut, and it is easier of manipulation.

It is true that small perforations of the small intestine by a small bullet have been known to close up by swelling without the escape of fecal matter into the cavity; under these circumstances, if no vessel were injured, it is possible the patient would recover without operation. In the majority of cases, however, where any bullet, even the small 22-caliber, has entered the cavity, it is probably a hopeless expectation to look for any other result except fecal extravasation, and practically the result of fecal extravasation is invariably fatal without abdominal section. In some instances, where large laceration of the abdominal wall has occurred, fecal extravasation might be prevented by external escape, and might suggest the propriety of establishing a permanent fecal fis-

tula. I feel quite sure, however, that it is scarcely wise to discuss this in surgery, as it is too rare to be practical.

Dr. I. N. Bloom: Given a case wherein a man has been shot below the umbilicus into the belly at short range with a large caliber revolver, and the patient, after going through a protracted illness, recovers—say after three weeks illness, some fever, and slight evidence of peritonitis, there having been no operation or exploratory incision of any kind—would you come to the conclusion that the intestine had not been perforated?

Dr. Dugan: If there were any evidence of peritonitis I should conclude that the intestine had been perforated.

To illustrate a point I made in my former remarks: I remember the case of a little boy who was accidentally shot with a 32-caliber rifle through the abdomen, the bullet ranging through and coming out just in front of the kidney on the opposite side. A young physician was called, a man who had never performed or assisted in a laparotomy. He told the family that the boy would certainly die, that there was absolutely no question about it. He urged upon them the advisability of an operation, but with the meager chances he suggested of recovery they would not consent to it. That boy recovered, and was about his play at the end of a week.

That young man was a good physician; but if he had opened the abdomen in this case, inexperienced as he was, I hardly think there is a surgeon present that would question the patient's chances of recovery. The operation would have been very grave indeed without surgical surroundings, without hospital advantages, and without surgical experience. The patient would most likely have died with the operation, whereas he recovered without it. We should not judge hospital cases by those we have on the outside. Any surgeon is liable to be called to see a case, in a negro hovel, for instance, where the patient will not go to the hospital, and if operation be performed in such a case, with the decidedly unsurgical surroundings, with nobody to nurse the patient afterward, I believe death will result in 99 if not 100 per cent of all cases, and it will simply be a stigma on abdominal surgery. I should like to go on record as stating that the majority of these cases should be operated on if they could be placed where they could be cared for, otherwise I think the operation should be discouraged.

The statistics of Stimson (who is one of the greatest surgeons in the world), compiled since the day of antiseptic surgery, show that the

mortality is four per cent in favor of non-operative work. We can not afford to turn our backs upon the statistics of such a man as Stimson. Ideal surgery is not always the best surgery. It is the best surgery that saves the greatest number with the least fatality, with the least amount of suffering.

Dr. Grant: I believe Stimson states in his paper that a number of cases recovering were not verified by any positive evidence of there having been a perforation. A great many of them did not have any verification of it, consequently the mortality of his report should not be considered, except in so far as there is positive evidence of perforation. The position I took (and the position I think we all ought to take with respect to surgery) is that it should not only be in competent hands, but with safe surroundings. Of course we can not expect to instruct people, who are too ignorant to give an emetic or an injection in the treatment of conditions where it is absolutely demanded, to locate brain tumors and do hysterectomy, still it would be folly not to teach that this is the proper method of treatment when in order; and, if we take the position that we are excusable in allowing such neglect of treatment, we fail to urge upon the authorities to put such conveniences and facilities around a populace as safety and security demand. I think we ought to teach what is right; we ought to teach principles, and not make allowances that are inexcusable and unscientific, which will allow a loop-hole for ignorance or even criminal neglect. What I said was in support of a surgical principle, not isolated cases, and not supposed to be any exception to that universal law "that there is no rule that has not an exception." The principle I mean to advocate is, that if a surgeon has a case of gunshot wound into the belly he should not waste precious time in futile conservatism, not that he would be expected to take a pocket knife and slash open the abdomen and sew up the cuts with a dirty string. What I meant is the principle that it is our duty to advocate operative interference in all conditions of this kind, and not be misled or be dissuaded from operation by the consideration of statistics that I think scarcely have any bearing in the present advanced state of surgical science. I do not mean to underestimate any thing that Stimson says, but I do mean to say that in this particular there has been a marked advance in surgical science, and it will only be perfected when the principle is impressed upon those who are beginning to practice surgery and who are being taught it.

Dr. W. L. Rodman: There is perhaps no subject at the present day

that surgeons are more in doubt about than they are as to what they shall do in cases of wounds of the abdominal wall, whether they have penetrated the cavity or not. Now it seems to me that the first thing to do in either a stab or shot wound is to satisfy yourself beyond any doubt as to whether or not you are dealing with a penetrating or non-penetrating wound of the cavity. I think that the symptoms in these cases will generally be misleading. We will not always find shock and other symptoms that sometimes present themselves after shot wounds of the gut particularly, and I am one of those persons who believe very much as Dr. Grant does. I think that in all shot or stab wounds of the abdominal wall, I do not care if there is entire absence of all symptoms indicating perforation of the cavity, it is at least the surgeon's duty to disinfect his little finger thoroughly, not to use a probe, because it is very easy with it to convert a non-penetrating into a penetrating wound, and carefully examine so as to determine beyond a doubt whether or not the cavity has been opened. If necessary the external wound can be sufficiently enlarged to admit of free exploration with the finger. Now, having ascertained that the cavity has been penetrated, especially if you are dealing with a shot wound, as we are discussing to-night, I believe that statistics all prove that ninety-nine times out of one hundred some one of the important viscera will have been injured, and I fully agree with Dr. Grant that it is our duty to do a median laparotomy, search for the injured viscus and repair it. I believe this is what we should do in every case.

Concerning the statistics that have been referred to to-night, of course memory is uncertain, but I am of the opinion that Stimson makes a stronger statement in regard to shot wounds of the small intestine than Dr. Dugan gives him credit for. Unless I am very much in error he makes the statement almost in these words: "There is no incontestible case of recovery on record, of all the men shot during the War of the Rebellion, after wound of the small intestine." Abernethy said that "Nature will do nothing for these cases, but leaves them to their fate." Stimson does say in the same connection, however, as Dr. Dugan has remarked, that there were a number of cases of wounds of the large intestine that recovered during the war. Of course we know that most of the cases shot during the war may have been shot with minnie balls or very large bullets, consequently would have very slight chance of recovery, whereas a man shot with a 22-caliber bullet would have a better chance to get well; fecal extravasation might not take place after

injury with a 22 bullet. I can well understand how some of these cases will get well, but I agree in the main with Dr. Grant, that while admitting the possibility of shot wounds of the small intestines getting well when they have been made by a small bullet, at the same time I believe that the dangers of fecal extravasation and peritonitis are greater than the dangers of a laparotomy. I have had four cases of shot wounds of the intestine, only one of which recovered.

No. 1. The first case I operated on in the City Hospital early in 1887; this was the first case operated on in the city of Louisville, or, so far as I know, south of the Ohio River. The man was shot in the right side above and midway between the umbilicus and the liver. He had been in a fight in a bar-room one Sunday morning about 2 o'clock. I had him sent to the City Hospital, and as soon as I could make arrangements did a laparotomy by candle-light, as we had no gas in the hospital at that time. I found the left end of the left lobe of the liver loose in the peritoneal cavity; found two wounds of the small intestine, and a large quantity of blood in the abdominal cavity. I repaired the wounds of the intestine as promptly as I could; there was no bleeding from the torn surface of the liver, so I let that organ alone, stitching the capsule with fine catgut. This man died of peritonitis in about twenty hours after the operation.

No. 2. The second case was in a mulatto boy, about sixteen years of age, who was sent to the City Hospital, having received a wound to the right of the median line midway between the umbilicus and the left anterior superior spinous process of the ilium. Drs. Vance and Cartledge came in at the time and saw the case with me. A median laparotomy was done, and two large wounds of the gut were found, one of them large enough to permit extravasation into the peritoneal cavity of a considerable quantity of fecal matter, and along with the feces an apple-core which the patient had swallowed. This patient lived, so far as I remember, thirty-six or forty-eight hours.

No. 3. The next case I saw was a negro, about twenty-six years of age, who was brought to the City Hospital on Christmas day, 1891. I found a wound just above the bladder. The interne at the Hospital thought the bladder was injured; I did not think so. A median laparotomy was performed after exploring the wound with my little finger and satisfying myself that the cavity had been opened. I found seven complete perforations and two incomplete wounds of the small intestine. These were all repaired very promptly, as I had good assistants. This

man was not on the table more than thirty or thirty-five minutes. I completed the operation in less time and more satisfactorily than any I had ever done before. During the time I was operating I noticed a white, flaky fluid, which would occasionally come out of the abdominal wound, and I remarked to the assistants that I thought the patient must have had tubercular peritonitis, as I could not understand that flaky stuff coming out of the peritoneal cavity. The man was put to bed in good condition, little or no shock. When I made my round the next morning I noticed what seemed to be pus discharging from the drainage-tube. On examination it proved to be the flaky-looking material which we could not understand at the time of operation; the interne said that quantities of it had passed during the night. I said then that I believed the man had a lumbar abscess which the pistol bullet had opened, and that explained the peculiar looking fluid. The discharge from the drainage-tube was unquestionably pus, there could not have been any doubt about it. The man developed peritonitis at twelve o'clock that day, and died late in the afternoon. We made an autopsy, and found that my suspicions were correct in regard to the lumbar abscess. All the wounds in the intestine had closed perfectly; there was no great amount of inflammation around the wounds; the intestine was tested by the water test, and all the rents were seen to have been completely closed. We found in the peritoneal cavity a large quantity of pus, certainly not less than a pint and a half or a quart; then searching further back we found the bullet had entered a lumbar abscess, which had partially emptied itself into the cavity. This man was the first and only one of the three that I thought had any chance to recover. I believe that he would have made a good recovery, notwithstanding he had seven complete wounds of the intestine, had there not been this unique feature in the case—the bullet penetrating a lumbar abscess, the pus pouring into the peritoneal cavity and causing peritonitis.

No. 4. I was called by Dr. W. Carroll Chapman, the day after operating on the case above reported, to see a case down town that had been shot on Christmas day. I found a negro girl, about fourteen years of age, who had been accidentally shot by the discharge of a pistol in the hands of a cousin of hers, the bullet being rather large, probably a 32- or 38-caliber. The ball had entered below the middle of the crest of the ilium, ranging downward. I could trace it down to the sacro-sciatic foramen, and it had gone into the pelvis at that point. I found the child on the morning of the 26th with high temperature, 105.5° F.,

pulse very frequent, belly tympanitic. I asked the question, if she had passed bloody stools, and they said she had passed two or three tablespoonfuls of blood a few minutes after being shot; she later had an action of fecal matter, and it was freely tinged with blood. So I have no doubt in the world that the intestine was injured in this case. Not seeing the patient, however, until the next day, and the child already having a tympanitic belly and other symptoms which led me to believe that the time for a laparotomy had passed, I concluded to see what this case would do without it. The wound was freely enlarged, irrigated, and plugged with iodoform gauze. I thought that I could detect a fecal odor in the discharges coming from the wound. We let the case alone, draining it well, and the girl made a beautiful recovery, and is well to-day.

Now I do not think there can be any doubt about the intestine having been perforated, otherwise I can not understand why she passed blood after being shot. She later on passed fecal matter which was also thoroughly mixed with blood.

The statistics in these cases I think prove one thing, that if operations are to be done at all they should be done promptly. And I for one, profiting by my own experience in four cases, and also by a number of others that I know of here in Louisville, as well as others that I have read of, am satisfied in my own mind that the best procedure is to operate upon every case of shot wound of the cavity, and I shall do so in every instance where I reach them within two or three hours after the injury. I believe that an operation done as late as ten or twelve hours after the injury gives very little promise of success, if Coley's statistics are to guide us. He was the first to make any thing like complete statistics on the subject, and, in his paper in 1889, he made it very clear that if you are going to operate with any hope of success you must do so early. I advocate operation in these cases, but I do believe that you must operate very early. After much fecal extravasation has taken place, and if the fecal matter has been in the cavity several hours, I do not think there is any chance of recovery.

Dr. Dugan: I had one case of gunshot wound of the bladder, which was peculiar in some respects. The man recovered without operation, but I have always been of the opinion that there was simply a slit in the bladder, and no extravasation of urine. The bullet was afterward removed from the bladder. Now, whether it was intra- or extra-peritoneal I am unable to say.

Dr. Grant: I would like to ask Dr. Rodman if he does not think in the last case reported by him there was perforation of the rectum behind the peritoneum.

Dr. Rodman: I thought of that; but why should the patient have had swelling of the belly, etc.

Dr. Dugan's remarks call to mind a most interesting case I saw when I was surgeon in the army: Dr. J. W. Bannister, Assistant Surgeon at Ft. Reno, Indian Territory, had operated upon an Indian scout who had been shot through the ilium, and he afterward removed an enormous calculus from the bladder. The bullet had evidently crashed through the ilium, and had either gone into the bladder or driven a splinter of bone there which acted as a nucleus for the formation of the stone. He reported the case in the *American Journal of Medical Sciences* about July, 1880, I think, and I afterward saw the patient.

Dr. Turner Anderson: Shot wounds of the bladder are not so very uncommon, where the ball lodges in the bladder. A case occurred in my practice a good many years ago. The history of the late war proves that there are numbers of cases of shot wounds of the bladder, the bullet lodging in that organ, taking all sorts of directions to get there.

Dr. J. G. Cecil: My experience in the matter of shot and stab wounds of the abdomen is very limited. I am clearly of the opinion, however, that in all shot wounds, where it has been demonstrated that the shot has been a penetrating one, it is safer to investigate further by a laparotomy, or by enlarging the opening, than it is to leave the patient to the chances of nature. There will be very little additional shock by the operation added to that already existing, if there be any, and you clear up all doubt in the case, which is a very important factor, and which, if left to develop by symptoms of an inflammatory kind indicating peritonitis, sometimes render it too late for operative procedure. I have seen several cases of the kind in the practice of other gentlemen, and have always been of the opinion that early operation was the thing to do.

As for stab wounds, my practice in this class of cases amounts to little, and my opinion is merely theoretical. It seems to me, however, that if there is a very profound impression—and I am aware while I am saying this that this alone is not a safe guide—that where there is a profound impression from stab wounds of the abdomen, it would be safer to investigate with view of determining if there be a wound of the intestine. We often see directly contrary statements made by men who

are equally competent to judge. One man reports six cases upon which operation has been performed, in which there were five cases of gut wounds; another reports several cases of stab wounds of the abdomen and no wound of the gut. If you take these and put them together, rather, if we take all cases reported here, we find that a very considerable proportion of stab wounds of the abdomen also have stab wounds of the gut. Now, when we consider that there is so little added to the original danger of the case by exploratory incision or enlargement of the stab wound under the advanced and very thorough surgical measures, I do not think we ought to leave these cases in doubt, and certainly if I were called to see a case of stab wound of the abdomen with profound impression, whether I saw at once evidence of gut wound or not, I should be very much disposed to investigate further.

I was quite impressed by the remarks of Dr. Vance at the last meeting of the Medico-Chirurgical Society in regard to the method of investigating these wounds. I have been associated with him in one or two cases of this kind, in which, in examining the gut, large quantities were unavoidably exposed at one time. I think this is unfortunate, and should be avoided if possible. There is an impression made upon the intestine by exposure to the atmospheric air and cold, and this should be avoided. If it is possible, the method that he adopted in the last case is the correct one; that is, reading the gut and putting it back as you read, repairing it as you go along, at no time exposing more than a few inches of the gut. In this way we avoid exposure and shock to the intestine, which is a very important factor in the final recovery of the case.

Dr. Vance: I have very little more to add, after thanking the gentlemen for the very free discussion of this subject. I am convinced from my own observation that when a bullet perforates the bowel that death will follow if this perforation is intra-peritoneal. If we are satisfied at the time that the missile has entered the cavity, exploration is in order. The condition of the patient generally when this point is reached should, of course, be considered, also the surroundings. We should be always prepared ourselves, get the best assistants possible, and get to work as quickly as we can, in the best surroundings obtainable in each case; do the work quickly, exposing the abdominal contents as little as the injury will allow, and particularly doing as thorough cleansing with a long douche tube as the condition of the patient will permit. If any time is wasted let it be in irrigation. I think we should even strain a point

in favor of operation in every case, as often the forlornest of the forlorn cases in abdominal work will be successful. One point of importance has not been mentioned, the fact that death comes from extra-peritoneal injury which it is unsurgical to attempt to repair, as after the intestinal wounds have been attended to there is no more resistance left on the part of the patient. I mean wounds of kidney, ureters, great vessels, etc., also the wounds of the solid viscera are often beyond repair, and cause death after the intestines are made intact.

JAMES S. CHENOWETH, M. D., *Secretary.*

Abstracts and Selections.

A REMARKABLE INSTANCE OF CURATIVE EFFECT OF EXPLORATORY LAPAROTOMY.—In a paper presented to the Société Anatomique de Paris Pierre Delbet (*Bulletins de la Société Anatomique de Paris*, 1892, October and November, p. 681,) records a remarkable instance of the curative effect of an exploratory laparotomy upon a case of syphilis of the liver. The patient was a boy of two years and four months who had always been delicate. Toward the age of a year and a half he had presented a generalized eruption, which had yielded rapidly under alkaline baths prescribed by the family physician. Shortly after this the child had commenced to fail, and lost appetite. It was soon noticed that the abdomen was becoming enlarged, and a blister was applied to the right hypochondrium. The health, however, continued to fail until, at the age of two years and four months, he was seen for the first time by the author. He was then greatly emaciated, the skin presenting a pale yellowish tint, but not jaundiced. The abdomen was greatly enlarged, the right side, from costal border to the iliac fossa, being filled with a tumor continuous with the liver. Its surface was smooth and firm to the touch. Syphilis was immediately suggested, but in spite of the eruption previously noted this was positively rejected by the family attendant. The only possible alternative was to attribute the growth to malignant disease (sarcoma) with very grave prognosis. In view of this, an exploratory operation was made, and showed that the tumor consisted of the enlarged right lobe of the liver, which was pale in tint, with violaceous marblings. A mass of enlarged glands could be felt in the gastro-hepatic omentum, while along the external border of the rectus abdominis, just outside of the peritoneum, was a chain of nodes like indurated glands. One of these was removed for study, the impression at the time being that the case was one of diffused sarcoma, and therefore unsuitable for further inter-

ference. Before closing the wound several punctures were made in the liver at the request of the physician, but they revealed nothing. The operation was thus purely exploratory.

The result was surprising. After three days the child regained appetite and cheerfulness, which had been lost for several months. Even before the sutures were removed he was kept in bed with difficulty, and as soon as permitted began to play with other children. He ate, thrived, and complained no more. The liver rapidly decreased in size, and therefore, no longer doubting the syphilitic nature of the disease, the author advised specific treatment, but was still opposed by the physician, who again refused to accept such a diagnosis. Two months and twenty days after the operation the liver had regained its normal dimensions. A few days later, however, three gummata appeared almost simultaneously, one upon the forehead and two in the scalp, and positively proved the nature of the affection, after which anti-syphilitic medication was begun, but at a time when the liver had already returned to its normal size.

Delbet reports this very singular observation, but does not presume to offer an explanation, although he does not accept as satisfactory any of the theories heretofore advanced.—*American Journal Medical Sciences.*

TRIONAL AND TETRONAL AS HYPNOTICS.—Dr. Samuel Garnier, head of the Dijon Asylum, has followed up his careful experiments of 1888 on sulphonal by another series on the use of trional and tetronal as hypnotics for the insane. The use of sulphonal was at the first much too enthusiastic, and it has been found to some extent disappointing after a more thorough acquaintance. Dr. Garnier was very prudent before in his praise of sulphonal, and remains still very prudent in his praise of its more recent congeners, but he wishes to record his conviction that they will all prove of some service both in general and in asylum practice. Both trional and tetronal are white crystalline substances, more bitter than sulphonal, almost insoluble in cold water, easily soluble in boiling water, and to a moderate extent in alcohol and ether. He prescribes them generally in honey or jam. Their hypnotic effects are very decided, and are produced more quickly than those of sulphonal. He has not used any dose beyond sixty to seventy grains per diem, giving this sometimes in one large dose in cases of acute mania with excitement. In subacute cases he has got good results with smaller doses. In cases of incipient general paralysis he has found the use of them less satisfactory, as they produce some signs of active cerebral congestion. He does not consider his knowledge as yet sufficient to decide which of the three (sulphonal, trional, or tetronal) would be most appropriate to a given case, and he finds the German observers discordant in their results. The price of both trional and tetronal, as supplied by the wholesale factories, is at present considerable, being about £3 per pound, but it is very likely that the price will be reduced if they are widely used.—*Le Progrès Méd.; London Practitioner.*

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INTEREST IN MEDICAL MEETINGS.

The question of maintaining interest in medical societies seems to be agitating the minds of some of our Eastern contemporaries.

When one surveys the published reports of the numerous medical societies of our great American cities, he naturally wonders how so much matter can be gotten together weekly or bi-weekly and maintain the flavor of freshness, which alone can make palatable the necessarily dry prolixities of scientific literature.

In this day, when most of our medical books are merely personal advertisements, being lame attempts on the part of their authors to ride into fame upon the shoulders of previous workers in medicine, it would not be surprising if medical papers and discussions should sometimes exhibit on the part of their authors a disposition to resort to the same expedient.

Be this as it may, the medical society is the only agency that can keep the profession of any locality abreast of the times; and if the proceedings contain nothing more than well-written reports or cases occurring in every-day practice, with such exchange of opinion as the discussions usually call forth, they can not fail of interest to any doctor who is engaged in the daily uncertain tussle with disease and death, and such only are the qualified critics of medical society proceedings.

Whatever may be the condition of things in the East, it can not be denied that the medical societies of the West are well attended, the number of essays large, and the discussions spirited and full.

The following suggestions by our learned brother, the editor of the Boston Medical and Surgical Journal, may be well pondered by the frequenters of medical societies East and West, and if heeded would materially enhance the interest of the meetings:

How can the meetings of medical societies be made interesting? This question worries the chairman and secretary of most societies; but the non-official members generally merely criticise, or stay away if the meetings are tiresome. The drawing power of a society often depends as much upon the by-laws and the activity of the officers as upon the capability of the members. It is necessary first to attract an audience, and then to keep them interested; this being accomplished, the value of the proceedings may be left to the individual speakers. The greatest bore is a paper ten times as long as it need be.

The adoption of the "Ten-Minute-Paper" rule has recently become a marked feature in the work of the New York Academy of Medicine, especially in the Section in Pediatrics, and has resulted in a marked increase in the attendance at the meetings, and a large number of concise and interesting papers. The instructions to writers of papers by the chairman contains the following: "Hippocrates and Galen may be passed with very slight notice, as they have been dead for some time and their opinions are somewhat obsolete. Scratch out the formal introduction, and condense the body of the paper. End the paper where the subject matter ends, making its action like that of a piston syringe—begin, spatter, stop."

A busy man is more easily persuaded to write an informal short paper than a formal long one. The formality itself, and the necessity of 'clothing the main idea is often the bugbear which prompts a man to decline to write. If his contribution is to be one of six, instead of the *pièce de résistance*, it is easier for him, and generally much easier for his audience. In drawing deductions from a case, or a series of cases, a reader is readily excused from going into the details of his process: he is not proving a geometrical problem, or if he is, his hearers had rather see the steps in print, where they can be skipped, than listen to them.

The discussion is generally an interesting part of a meeting. There is usually too little rather than too much, but it would be acceptable to most societies if those gentlemen who have a rambling and procrastinating tendency could be helped along.

The reader as well as the listener will be more readily attracted by a condensed than by a well-padded paper. No one, except, perhaps, the writer, thinks that there is more dignity in a long than in a short article. The reader has the advantage over the hearer in that he can skip, and look to the end for the conclusions; but the process is not a pleasant one to him. He is repelled by tables and by copies of hospital records, and attracted by short articles or well-described descriptions of single cases.

AMERICAN MEDICAL EDITORS ASSOCIATION.

This Association will hold its eleventh annual meeting in Milwaukee, Wisconsin, June 5, 1893. The programme, as might be expected when so wordy a set of fellows as American medical editors get together, is stuffed to repletion, but nevertheless finds room for an address by Mr. Ernest Hart, the eminent editor of the British Medical Journal.

It is not improbable, in view of the facts that this is the season of the Columbian Exposition, and that Milwaukee is merely a suburb of Chicago, not a few of the great medical literary lights of the Old World will honor the Association with their presence, and thus contribute to the meeting of '93 attractions which it may never again possess. We expect to be there, and hope that no one of the editors of our "esteemed contemporaries" will miss this opportunity of seeing the great, and being seen by the same.

Notes and Queries.

THE CONSEQUENCES OF TIGHT LACING.—It would still be premature to conclude that we have done with the practice or ill effects of tight lacing. Were we disposed to doubt the prevalence of this custom the medical records of every day could prove its continuance, nor can we see how it could be otherwise as long as the stiff corset retains its place as an article of dress. Now and then some fatal mischance is found to be traceable to its abuse, while instances in which ill health has been the penalty are far from uncommon. Every practitioner is familiar with cases of this kind, and it needs no searching examination to convince him that among the pallid complexions and palpitating hearts which require his attention some are directly traceable to the pinching vanity of the corset. Why this effect should follow such a cause we need hardly explain to medical readers. They can well appreciate the vicious influence of cramping pressure exercised upon the trunk and its viscera without cessation for the greater part of every day. Let us nevertheless discuss briefly the effect of such pressure upon the different organs exposed to it. Naturally the kidneys, being deeply placed, may be expected to escape entirely from its direct action, and they constitute the sole example of such immunity. The lungs and heart suffer almost if not

in equal degree, and the consequences in their case are visible in impaired respiration, defective nutrition of the blood with consequent impoverishment of every organ and tissue, and a weakened and excited or languid cardiac action, culminating, it may even happen, as in an instance lately reported, in fatal syncope. The effect upon digestion is noteworthy. There being but little space for the normal expansion of the stomach after eating, less and less food is taken till the foolish sufferer is virtually half-starved. Constipation is a necessary sequel, and flatulent distension adds another impediment to the course of a laboring circulation and overpressed respiratory organs. Naturally those viscera which lie low in the pelvis likewise feel the strain, so that almost every function required for healthy existence is deprived of its normal exercise. What then of health itself? And need we feel surprise if now and then the thoughtless vanity which thus exchanges every physical comfort for mere appearance leads to forfeit of life also? If experience be credited, it is so.—*London Lancet*.

THYROID GRAFTING IN MYXEDEMA.—At the recent Congress of the French Association for the Advancement of Science, Bouchard (*Arch. Gén. de Méd.*, October) presented a communication in which he stated that as far back as in 1887 he had had a woman suffering from myxedema under his care in the Lariboisière Hospital. It occurred to him to make some physiological experiments on the function of the thyroid gland, and with that view he removed the organ from twelve dogs, and placed all the twelve thyroids inside the peritoneal cavity of a thirteenth dog. After time had been given for the grafts to take the latter was deprived of his own thyroid. He survived the operation ten days, whereas the other dogs had all died within five days; and on *post-mortem* examination it was found that two of the twelve grafted thyroids were living and had established vascular relations with neighboring parts. There being difficulties in the way of grafting dogs' thyroids in the human subject, Bouchard bethought himself of the feasibility of injecting thyroid juice instead. He was confirmed in this idea by the results obtained by Brown-Séquard with his injections of testicle juice, and he ultimately carried it into execution in conjunction with Charrin, both in the patient already referred to and in another woman in the Charité Hospital. The results in both cases were astonishingly rapid, and highly favorable as regards the chief symptoms, both bodily and mental. The treatment was, however, attended with certain drawbacks, notably headache and pains in the limbs and chest, which several times made it necessary to interrupt the treatment for four or five days. As to whether the thyroid juice is really the active factor in the therapeutic results he obtained, or whether the same end might have been attained by injections of other organic liquids, Bouchard declines to commit himself. He expresses the opinion that the improvement is only temporary, and does not believe that actual cure is likely to be effected by the method.—*British Medical Journal*.

THE AMERICAN PRACTITIONER AND NEWS

"*NEC TENUI PENNĀ.*"

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Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

CROUP, DIPHTHERIA, AND TRACHEOTOMY.

BY R. A. PRICHARD, M. D.

It is not my purpose at this time to enter at length into the differential diagnoses of croup and diphtheria, but to lead the reader to a comprehension of those morbid phenomena which mean fatal asphyxia unless tracheotomy be executed. There is presumably a radical distinction between croup and diphtheria; but when an inflammatory exudate interferes with aeration or respiratory functions it makes little difference to the surgeon whether the disease be specifically one thing or another. A laryngeal stenosis is to be overcome by operative measures. An aperture large enough for respiratory purposes must be made in the trachea, and kept pervious until the exudate has been detached and cast off.

Diphtheria is generically zygomatic and constitutional, and contagious withal, while croup is or may be a local manifestation, a plastic laryngitis. A startling croup may develop in a few hours, but, on the contrary, diphtheria requires several days, as many as three or four or more, to go through with its peculiar evolutions before the faucial, pharyngeal, and laryngeal exudate is to be seen. In other words, the essential toxic quality of diphtheria is commonly inhaled, either from the breath of an infected individual or from the atmosphere of a contaminated room.

In cold and damp weather the air of a sleeping-coach on a railway is poisonous for weeks together, and so it is in the unheated and unventilated sleeping apartments of hotels and boarding-houses. In

two or three days after the poison has been inhaled the digestion is impaired, if not wholly arrested. A pain is felt in the muscles; especially is the soreness felt about the neck. The throat now becomes sore, febrile signs are now observable, and aversion to work or exercise is experienced. A painful sensitiveness about the angles of the jaws is developed, and an unusual tenderness of the tonsils. Sometimes a chill or rigor is experienced, and terrible aching of the back and limbs. At night there is delirium and muttering during sleep. The pulse runs up to 90 or 100 per minute, and the temperature of the body reaches 104° more or less.

The breath is offensive, and the perspiration is rank. The urine is scanty, and may be nearly or quite suppressed. A catheter has to be used in typhoidal states. The bowels are usually flatulent and distended, and the appetite and digestion *nil*. If the tonsils be examined in a good light they appear quite red, and exhibit white patches here and there of diphtheritic exudation.

In ordinary cases the exudates will remain for several days in much the same condition as seen at first. In more severe forms of the disease the tough, tenacious, almost membranous exudation adheres firmly to the surfaces producing it, and spreads to the nasal chambers, the larynx and pharynx, if not to the trachea and bronchial tubes. In an ugly state of the disease the lymphatics of the neck are swollen, thus adding to the fullness and discomfort of the cervical region of the victim. If the mucous membrane of the larynx is thickened, as it is likely to be, the patient becomes distressed for breath, and a blueness of the lips (cyanosis) is observed. At this stage of the disease danger is present, whether the medical attendant of the patient recognizes the situation or not. I have seen a child clutching at its throat and exhibiting apnea, and the physician in charge contending that his patient had been previously worse and was now convalescing, citing in support of his views that "the pulse was less frequent and that the temperature was lower or normal." In one case I call to mind a uremic state had come on, the poison lowering the pulse and the temperature.

In most cases of diphtheria a more or less harassing cough is a concomitant or sequence. A profound state of debility is experienced in all cases, and typhoid symptoms are usually present. Whistling, squeaking, and flapping sounds of the breath are heard if the larynx be invaded, but the crowing sound of croup is rarely manifest unless the disease be more croupal than diphtheritic.

Croup differs from diphtheria in the essential particular that it is principally and substantially a *local disease*. However, in the more severe types of croupous disease there is evidently, in my opinion, some blood poisoning and marked systemic disturbance. When an assault of croup is made without any previous warning in the way of fever, sore throat, and hoarseness, the onset is local, though a constitutional impression may soon follow.

It is no uncommon occurrence for a child to go to bed in good health, yet be voiceless before morning through plastic exudation into the larynx. There would at first be no pyrexia or systemic tumult, though the worry and excitement provoked by repeated attempts to talk might develop general disorder in a short time.

An attack of idiopathic croup is usually preceded by a day or so of huskiness in the voice, and dryness of the vocal organs. In a typical case there is at first hoarseness, with occasional breaking or cracking of the voice, an audible sound descending to a whisper, or failure to articulate a word.

Every effort to speak seems to aggravate the aphonic state, and several varieties of vocalization may be heard within a few minutes. There will be crowing sounds, shrill whistles, and harsh croaks and husky rattles, all indicating laryngeal stenosis. Respiration at once becomes hurried, labored, and distressing, and each inspiration is attended with a sibilant rale. There will be an interval of ease, which is followed by aggravation of the disordered sounds.

In other words, the manifestations of croupous disease are paroxysmal. If no relief be obtained at once or early, signs of suffocation become pronounced. A child pushed to apnea instinctively clutches at its throat, or puts its fingers into its mouth to indicate the seat of the trouble. The viscid mucous adheres to the fauces, and helps to obstruct the already narrowed and occluded respiratory passages. If the exudate be in patches, a flake of half organized material may now and then be coughed up; but if it be decidedly membranous, a continuous or unbroken exudate, a "cast" is not seen till later, and the obstruction is then greater. The chink of the glottis is the narrow passage threatened with a degree of stenosis that forces asphyxia.

The voice is gone, but the staring of the patient's eyes *touchingly* plead for relief. A desperate struggle is made, as if to shake a monster from a grasp of the throat, but the weakened victim settles back for a season of rest, the lips becoming deeply cyanosed, as time passes, in

fruitless effort to get clear of the terrible and relentless grip. Now, if not before this, is the time for the surgeon to display his skill, for I believe that many times (in fact in most cases) surgical interference is delayed too long, and that it should be resorted to, all things being equal, on the appearance of approaching cyanosis. The average therapist can see at this point that active measures of some kind are called for promptly, hence he may administer as many or as few of the almost endless list of remedies which are recommended for this disease (as in all grave troubles such as might here be mentioned), and locally the heat and wet and poultices hot, etc., notably inhalations of medicated steam from the croup-kettle. The temperature of the room should be kept as high as can be endured without annoyance.

The treatment of diphtheria, from what has been said, is to be constitutional as well as local. A septic influence is to be counteracted, and a depressed degree of vitality to be anticipated and hindered as far as possible. The indications are for antiseptics and nutrients.

Iron and quinine evidently stand first as meeting the indications, nutritious food and alcoholics filling the second. I might continue at length upon the subject of treatment from a medical standpoint, but such is not my intention at this time, viewing the matter from a more purely surgical standpoint. Suffice it to say that the foregoing, it matters not how judiciously, energetically, and skillfully applied, is of no avail, and the point is reached where the operation of tracheotomy must be resorted to, or speedy death is the result.

Tracheotomy. In a certain per cent of cases of diphtheria, as well as croup, medication is acknowledged on all sides to be incompetent to arrest the morbid process or prevent fatal asphyxia. This is a trying time for the parents of the dying child. In the agonies of the moment they ask if something can not be done to avert the terrible ordeal. "Yes," replies the family physician; "we can make an artificial respiratory opening in the child's throat, and through that aperture the little sufferer may breathe easily until the diphtheritic laryngeal membrane matures and departs in slough." "But will the surgeon who proposes to cut the child's throat assure us that all will end well, that the little darling will not die? it would be cruel to mutilate the innocent sufferer and then have it die." The stern reply is that it is a *dernier ressort*, a last chance, and may prove, it must be admitted, a lost one; but, on the other hand, it must be borne in mind that in a laudable per cent of desperate cases tracheotomy when skillfully performed terminates the

case successfully. The surgeon who enjoys a well-earned reputation in his branch of the profession is not blamed if the results be not satisfactory. No medical gentleman will reflect upon his skill, except envy be the principle of action.

In the event of laryngeal stenosis, whether it be croupal or diphtheritic, and there be no reasonable hope except in an artificial respiratory channel, an aperture in the trachea may be deliberately made as follows: The patient, if a child, may rest in an adult's lap, the head falling backward somewhat to make prominent the neck between the larynx and sternum. It is not requisite that the patient be placed under the influence of an anesthetic at all times, unless there be great restlessness. The operator begins the incision over the thyroid isthmus, and extends the cut downward in the median line for an inch or two. The bleeding is unimportant. A divided vein is to be controlled by the grasp of a hemostatic forceps. The grooved director is to lift and display bands of fascia. With a bistoury divide them. The incision is thus deepened until the lower edge of the isthmus of the thyroid gland is exposed. The glandular mass is pushed away upward, and then the director (or the fingers) until five or six rings are exposed, and a bistoury incises the trachea. Air is sucked through the aperture, and shreds of false membrane are coughed up, perhaps. By this time the temperature of the room in which the operation is being performed should be 90°, and made moist by the discharge of steam from boiling water on a stove.

As soon as the patient is a little relieved from the asphyxia a tracheal tube is to be inserted into the tracheal aperture and pushed down *in situ*. The presence of the tube and the free rushing of air into the trachea excites fits of coughing, yet relieves the patient's suffocation by inhalation of an abundance of air. The cyanosis lessens, and alarming symptoms gradually disappear. The tracheal tube is to be cleansed every day, or even twice a day, if it gets clogged with tough mucus and shreddy material. The temperature and pulse of the patient usually decline rapidly after the tube is inserted, and the voice, which has been suppressed by the exudate, is not of course restored by the tracheal opening, but intonation is necessarily cut off until the air is returned through the larynx.

The tracheal tube is to be worn several days (three to six), or until the diphtheritic membrane has been disengaged and thrown off. As soon as the laryngeal stenosis is removed there is no longer any call

for the artificial opening in the trachea. After the tube is removed the aperture closes rapidly. The patient regains strength daily, and wants to be allowed every freedom. In the event a laryngeal stenosis be not operated on until the patient is in *articulo mortis*, little good may be looked for, but if there be any truth in the maxim, "As long as there is life there is hope," an operation is to be entered upon, in my judgment, even if the breath be seemingly gone. The great numbers of rescue from impending death call for action, though the knife come late.

It is to be considered that respiration through an artificial opening in the trachea may not do much good toward a better aeration of the blood. If the diphtheritic exudate clear through the tracheal and bronchial passages, cyanosis and asphyxia may still continue, though there be plenty of room for air to pass to the lungs and out again.

It should be remembered that tracheotomy is to relieve laryngeal stenosis or occlusion, and hence may help a patient through safely who has a diphtheritic exudation extending even into the smaller air tubes, and that the operation is not likely to aggravate the worst case of croupy dyspnea. Tracheotomies performed for the removal of foreign bodies that have slipped through the larynx are never in themselves fatal, hence the innocence of the operation when resorted to for the purpose of relieving pharyngeal occlusion produced by diphtheritic exudations when the proper antiseptic precautions are observed.

In making the primary incision over the trachea, the knife should divide the skin and some fat and fascia at a single stroke. Then the intermuscular connective tissue is quickly and readily raised on a grooved director and severed with knife or scissors. The trachea is now seen moving up and down with every breath, and is to be seized with toothed forceps and held still a moment while with a bistoury you divide three or four tracheal rings and the mucous lining of the trachea. Then the forced expiration throws out blood, mucus, and shreds of diphtheritic exudate. A severe fit of coughing is produced, but there is less of cyanosis, which shows that aeration of the blood is going on.

GARNER, KY.

THE ANTISEPTIC PROPHYLAXIS OF ASIATIC CHOLERA.*

BY GEORGE COWAN, M. D.

United States Commissioner McClellan, M. D., reporting on The Epidemic of Asiatic Cholera in this Country in 1873, puts in the forefront of the laws of personal hygiene the following recommendation, to wit: "On the development of cholera, it is well for all persons in whose power it may be to at once leave the country," to which he added the instruction which, under similar circumstances of necessity, Niemeyer had formulated in the form of rules in 1870 for the people of Europe:

1. To start soon enough;
2. To go far enough, and
3. Not to return until the last trace of the disease had disappeared.†

It was of course tacitly understood that physicians everywhere, and nurses wherever they might be found, were not included, but were expected to remain and battle, unaided by the well-to-do portion of the community, single-handed and almost alone in the unequal strife. This sacrifice of self, public sentiment and public opinion have always required of physicians and nurses, and they have generally acceded to the demand.

On the part of those who fled from the presence of the pestilence, and perhaps also, to some extent, on the part of those whose poverty compelled them to remain, this demand has never been based on any very strong confidence in physicians or their remedies to control the ravages of an epidemic of Asiatic cholera. Property owners and people of wealth, abandoning their homes under such circumstances so precipitately and in such numbers, have generally left the most valuable residences, business houses, and personal property of the place unoccupied and unguarded, thus inviting the worst classes at home and abroad to riot unmolested in a rich harvest of pillage and plunder. The presence of the medical profession, nurses, and a few philanthropists of the laity and a few clergymen it was hoped would furnish some protection to the property thus exposed, and help maintain some show of law and order. The more fortunate who could thus escape, although more or less conscious of the unchristian act of abandoning the poor to

*A paper read before The Central Kentucky Medical Association at Stanford, April 19, 1893.

†Page 73 of report to Congress.

a fate from which all shrank with equal dread, doubtless felt that their conduct was in a great measure justified or extenuated by the rules of prophylaxis of Asiatic cholera to which I have referred, and by the presence of the physicians, nurses, and some of the clergy, enforced, as they doubtless supposed, to some extent by public opinion.

Be this as it may, the facts are in nearly all such cases as stated. The well-to-do classes have heretofore generally abandoned at once all plague-smitten places to their poorer neighbors, the physicians and nurses, and to lawless pillagers. And they were not wholly blameworthy. They were simply obeying the law of self-preservation, enforced by the maxims of public and private or personal hygiene as formulated by the medical profession throughout the world until very recently. But, thanks to the discovery of Koch and the recently developed science of bacteriology, it is possible to inaugurate something better and more hope-inspiring.

If, however, the proper steps are not taken on the part of the profession and the boards of health to prevent a repetition of the means of prophylaxis so universally in vogue only twenty years ago, we may expect, if cholera invades our country this season, one of the most universal, wild, and panicky stampedes of population ever in any time or land witnessed before. Let us consider how greatly, during the short period of only thirty or forty years just passed, wealth, population, and facilities for rapid transit have been developed, and over such a widely extended area as our country, and we may then form some, though inadequate, conception of the rapid and widely spread dissemination of the cholera bacillus possible, if panics as formerly should be allowed to seize upon our people left in unprotected ignorance of what might be properly termed "the modern or antiseptic prophylaxis of Asiatic cholera." In the light of such a method of preventive measures, these panic-stricken crowds, aimlessly fleeing in every direction with railroad speed in the vain endeavor to escape the disease, are simply facilitating its spread and increasing its percentage of mortality with direful promptitude and haste.

The work of bacteriologists during the last ten years demands very hopefully an entirely new regime in the matter both of prophylaxis and treatment. Their investigations have demonstrated that cholera Asiatica is an infectious disease, caused by a specific agent, a living parasite which attacks primarily the alimentary canal. It is swallowed in drinking-water or food which has been contaminated, but becomes

active only in the alimentary canal, and then not until it has passed the pylorus.

Until quite recently the ordinary media of infection were recognized as being confined to personal contact with the sick, infected clothing, rags, etc., and water contaminated with cholera bacilli used for drinking or for ordinary culinary purposes. Experiments, however, first by Simmonds, and subsequently verified by Sawtscheuks, go to show that the agency of flies, hitherto suspected in some way as being carriers of the infectious principle, must be accepted as a very possible rational explanation of the theory once held of atmospheric transmission. Two exceedingly interesting articles, *Flies and Cholera* and *Flies as Agents in the New York Epidemic* are to be found in the *Boston Medical and Surgical Journal* for November 17, 1892, and February 16, 1893, in which the experiments are detailed in full, proving conclusively that "the cholera bacillus is taken into the bodies of flies feeding on cholera dejections, multiply during their sojourn there, and pass through without any loss of their active properties in large numbers as characteristic cholera bacilli."

It has been found that this parasite can not survive the degree of heat necessary to cook food, boil water, or very weak solutions of corrosive sublimate. Thus the germ, by the proper attentions to the necessary details in taking one's food, or waiting upon the sick and disposing of the bodies of the dead, or in contaminated articles of clothing, etc., may be easily destroyed. And we have it on the best authority in our country, that of Dr. Shakespeare (sent to Europe, India, and Egypt, in 1885, as the U. S. Commissioner to investigate cholera), that cholera patients may be visited, handled, and even slept with with impunity, provided the antiseptic prophylaxis is carried out thoroughly in all its details.

I have only hinted in a hurried way at these details of antisepsis. There will be undoubtedly great difficulty in enforcing it with a sufficient degree of thoroughness in rural districts and small towns where there is no organized medical police and where trained nurses are not to be had. Such help can only be had in large cities, where wealth abounds and municipal organization is sufficiently organized and extensive. But the more intelligent citizens of our country communities and villages can be sufficiently educated by persistent and well-directed efforts on the part of the medical profession to understand the practical application in personal hygiene of these recent discoveries in the

pathology of Asiatic cholera. Particularly should emphasis be laid on the fact that however easy and simple of practice this personal antiseptis is, it is only in one's own home, as a general rule, that it can be carried out with the requisite degree of certainty and precision.

If this simple method of personal hygiene could be universally accepted and put into practice the advice of Niemeyer and others, as late as 1870-73, would require to be reversed, so that the rules of prophylaxis might be restated as follows: "On the development of an epidemic of cholera it is well for all in whose power it may be to remain at home, and for those who are absent to return at once. Then let all unnecessary travel and traffic be put an end to by the boards of health or other authorities." To which might be added the following rules:

1. To begin early enough the study and practice of all the recently discovered details of individual prophylaxis for cholera.
2. To keep it up persistently and long enough; and
3. Not to leave home if possible until the last trace of the disease has disappeared.

Or, in other words, I believe we should from this on endeavor to teach the people of our respective communities that "there is no place like home," not only socially and morally, but also as the place where the most secure and efficient prophylaxis of cholera is practicable.

The people of every community remaining thus tranquilly at home, and inspired with a hopeful confidence in the new order of things, their services and means might be elicited and utilized by the profession in the establishment and maintainance of suitable quarantine stations and hospitals, whereby a proper care for public hygiene might be better secured, better service rendered the sick, and the bodies of the dead properly disinfected.

Do these suggestions appear fanciful or utopian?

In reply I would say that they are based on almost universally accepted conclusions of bacteriological investigations of Koch and others during the past ten years.

Incidentally it may be urged that the modern treatment which has been found most successful in the treatment of cholera, that of Prof. Cantani, of Naples, sustains the "stay-at-home" policy. The use of warm baths and such procedures as enteroclysis, hypodermoclysis, peritoneoclysis can not be obtained except in good homes or hospitals, and with the aid of good nurses or intelligent and willing friends. Such institutions and help can only be secured and equipped by the means

and efforts of all the people of every community remaining at their homes, where their combined means and efforts can be used in preparing for the threatened invasion to a better advantage certainly than in a panic-stricken flight.

As to the efficiency of these measures of treatment Prof. Cantani makes use of the following strong language: "The physician who knows how to use with courage and reliance laudanum, tannic enteroclysis, warm baths, and hypodermoclysis will have to record among the victims of cholera only those unfortunates who when he was called were already well advanced in the stage of cyanosis and collapse."

DANVILLE, KY.

SCIATICA.*

BY CHARLES B. LAWRENCE, M. D.

The subject of sciatica is one which should interest every practitioner of the healing art, inasmuch as it is one of the most distressing affections which fall within the scope of his observation, and causes more acute suffering to the patient than almost any other of the ills nerve is heir to.

My experience with this trouble has not been extensive, yet I can recall several cases which I have been called upon to combat, and some recent experience led me to select this for the subject of my essay. I shall not speak of the symptomatology of the disease, but will proceed to relate some cases.

CASE 1. The first case I ever saw in my practice was just after I returned from my first course of lectures, and my knowledge of disease was very limited. I do not remember my line of treatment, but the patient, a man about fifty years old, was relieved after a fly blister was unintentionally left on all night over the seat of pain, which was worst in the calf of the leg. The suffering in this case was intense, and the relief was appreciated, although it was secured at the expense of a very severe external sore resulting from the blister.

CASE 2. A laboring man about twenty-eight years old had a clearly defined case of sciatica, and was relieved by a single deep injection of morphia into the region of the nerve.

*Read before the Knox County Medical Society, March 16, 1

CASE 3. Man about fifty years old, furniture dealer, consulted me about one year ago. He had suffered greatly, and was barely able to walk. His suffering was greatest at night. He improved rapidly on a treatment by antikamnia to relieve pain, and iodide and acetate potassium as alterative and diuretic, and the last I heard from him he was getting along nicely.

CASE 4. This is the case which I most wished to report in this paper. Mr. T., aged fifty-two, carpenter by trade, had suffered from sciatica for seven weeks when I was called. He was very much emaciated and pale when I saw him. He had been given morphia until he did not want to do without it, but it was taken from him. He was intensely sensitive along the course of the nerve over the point of exit, in popliteal space, in calf of leg, and behind inner malleolus. The man was truly in a pitiable state, and very much disheartened. I tried all lines of treatment in succession without avail, except the relief of pain, but he did not gain in any respect so that he could get out. I grew tired of these methods of treatment, and finally put him on an alcoholic solution of nitro-glycerine, one per cent, commencing on one drop three times per day, and gradually increasing until he was taking five drops three times per day. His improvement was immediately noticeable. His color improved, his appetite returned, he gained in strength, he did not need any thing for the relief of his pain, and in ten days after the commencement of this treatment he met me at the door walking on his leg, which he had not done before in ten weeks. The day following (last Monday) he was able to walk to the store, a distance of three or four hundred yards, and his improvement has been uninterrupted since. Now what is the pathological condition? I believe it is that of inflammation of the nerve sheath. A writer in the *Therapeutic Gazette* a few months back argued this theory, and related cases which he treated on this principle by local abstraction of blood, with almost immediate relief in a great many cases. But this method of procedure would not be applicable to a person who was already emaciated and with no blood to spare. In such cases the nitro-glycerine fills the indications exactly. By paralyzing the muscular coats of the arterioles, and inviting the blood to the surface, it relieves the engorged nerve sheath, and brings about an equilibrium of the circulation, and thus subdues the inflammation. In addition to this, its stimulant action on the heart, as well as nerve centers, imparts vigor to the system in general, and the whole organism is benefited. I am aware that

this drug has been used in neuralgic conditions before, especially in the hospitals of London, but I think it has been used very little in this country, and I think it worthy of trial, and believe it will prove highly efficacious.

KNOXVILLE, TENN.

Reports of Societies.

THE LOUISVILLE CLINICAL SOCIETY.*

Stated Meeting, March 21, 1893, Dr. I. N. Bloom, President, in the chair.

Dr. W. H. Wathen: (Rupture of Pelvic Abscess; Sudden Death.) On last Tuesday afternoon I was called in consultation to see a woman forty-five years of age, widow, with several children grown, who was suffering with some distension of the abdomen, with pulse 80, temper-normal. Her temperature the day preceding was 102° F., pulse a little accelerated. The history of the case, as far as I could get it from her physician, was about as follows: The patient had suffered with pain in the abdomen, not well located, perhaps a year before. She was comparatively well after that until a week before I saw her, then, at the menstrual period, she exposed herself during cold weather and began to suffer with severe pain in the abdomen, mostly in the appendicular region, and just then diarrhea began, which continued two days. An opiate was given to stop it; then her abdomen began distending, and became tympanitic in every part, least tympanites just above the symphysis pubis and on the right side in the region of the appendix, with no special tenderness except in this region. Her bowels ceased to move, I think, about the time I saw her, and she passed very little gas after that, temperature and pulse remaining normal. No vomiting, except substances which she took into the stomach; no odor of the vomited material, and very little discoloration of it. She was a large woman, and was unable to get out of bed, and rather indifferent to every thing that surrounded her.

An examination *per vaginam* showed that the uterus and all pelvic structures were matted together, the hardness being more pronounced in the right side. No accurate diagnosis could be made, but the symp-

*Stenographically reported by C. C. Mapes, Louisville.

toms indicated appendicitis more than any thing else. It was decided to operate on her on Friday morning at nine o'clock. Thursday evening at ten o'clock her pulse and temperature were still normal. She said she was feeling better. Friday morning at six o'clock she vomited a little water that was taken during the night; she fell over as though strangling, and in fifteen minutes was dead. After death she passed a small quantity of fecal matter, having passed no gas for several days preceding this.

At the request of the family a *post-mortem* was made on Friday at two o'clock by Dr. Louis Frank, Dr. Wilson, Dr. Pfeifer, and myself being present. I will ask Dr. Frank to exhibit the specimen removed.

DISCUSSION.

Dr. Louis Frank: On Friday we held the *post-mortem*, as Dr. Wathen states, and when we first opened the abdomen a clear fluid came out. The thorax was not opened, as is usually the case. In separating the intestines, reaching the large bowel, we found that there were collections of pus which seemed to be sacculated by adhesions having formed between the loops of the intestines, also between the contents of the pelvic cavity and the posterior abdominal walls. We found a rather dark formation in the region of the appendix, looking very much like the appendix; however, it proved not to be, and searching further we found the appendix, which was in a perfectly normal condition, consequently we proceeded to examine further for the cause of the trouble. I present here the appendix, which has been opened: it shows no evidence of disease or thickening. After having gotten out all of the intestines, and finding nothing to account for the trouble, we proceeded to look into the pelvic cavity, and found the uterus in a normal position, as were also the left tube and ovary; but in the region where we should have found the right tube we discovered an abscess sac into which the tube had ruptured. The ovary on this side was found to be cystic. The abscess had ruptured into the pelvic cavity, otherwise there was nothing of particular interest to report. I think it is rather an interesting case, and shows how liable we are to make a mistake in our diagnosis from abdominal symptoms; how easily we might diagnose appendicitis from the symptoms, when the true nature of the trouble might be pyosalpinx or other pelvic troubles.

Dr. Wathen: This *post-mortem* makes the case a very interesting one. From our general knowledge of symptoms caused by peritonitis

and the accumulation of large quantities of pus, we can hardly understand how such destructive conditions could go on without causing more disturbance, especially of the pulse, because the pulse, we are taught in our text-books, is rapid and wiry in peritonitis, and we come to the conclusion if we have a pulse relatively normal in its frequency and in its volume that we have not much peritonitis. But it teaches the lesson that we can not rely upon the symptoms in peritonitis, either local or general, to indicate exactly or even approximately the condition of the peritoneal cavity.

You will find one abdomen distended very largely, and you will operate, believing that you will come in contact with large quantities of pus in the peritoneal cavity, diffused or localized; when the abdomen is opened there will be no pus anywhere, and you will find a little band of peritoneal adhesion constricting the bowel at one point, which is removed, and the patient recovers. In another case, where the indications of pus and of peritoneal infection are not so well marked, we find either diffuse peritonitis with the cavity filled with pus, or sacculated accumulations of pus. Another thing that this case teaches is the conservatism of the peritoneal cavity in its effort to resist general infection by pathogenous germs. When this pus tube ruptured, instead of causing, as we would naturally suspect from a large accumulation of virulent pus, general peritonitis, nature hurriedly threw out a protective wall against general infection, and even after this accumulation of pus, as much as a quart or half gallon, it was cut off from the general peritoneal cavity. The peritoneal structures which were not involved in the pus sac were perfectly free from infection. Another thing it teaches is, as Dr. Frank has mentioned, our inability to diagnose with any degree of positiveness the origin of these intra-abdominal inflammations, because the symptoms are localized frequently in one locality when possibly the origin of the trouble is in some other locality. In this case all the well-marked symptoms of pain and tenderness in examining the abdomen were in the appendicular region, and the trouble was found to be of tubular origin. The only evidence that it originated in the tubes was in examining *per vaginam*; these structures were found to be matted together; but they might have been matted together in appendicitis, because leakage of pus from the appendix could produce peritonitis of the pelvic structures. Just as in a case that I reported to this Society at its last meeting, all the symptoms complained of by the patient indicated appendicitis, but the *post-mortem*

proved that the trouble was entirely due to rupture of the gall-bladder filled with gall-stones. Just as in a case reported some time since by Dr. Dugan, where all the symptoms pointed toward appendicitis, yet when the abdomen was opened it was found the gall-bladder had ruptured. So it is utterly impossible to make a positively correct diagnosis in condition of the abdomen of this character from the objective and subjective history of the case. Another thing it teaches is that cases of tubular trouble ought to be very carefully looked into, and where a woman suffers from conditions which point to any thing of this kind she should be carefully watched, and operated upon in time to prevent a fatal termination. I believe this woman's life could have been saved had an operation been performed two weeks before she died.

Dr. J. G. Cecil: One of the most interesting points to me in connection with this case is the method of death, as to what really did cause the death of this patient. I would have expected in a case like this, after there had been rupture of an abscess sac, a general diffusion of pus throughout the whole abdominal cavity, then a rapid infection of the general peritoneum, and death in a few hours, say twenty-four or forty-eight hours; this would have been a perfectly reasonable explanation, but how a woman could die in such a condition as this without evidence of general infection, in such a short time, is to me entirely inexplicable. I could not suggest the possible method of death in this case. She could not have died of hemorrhage, as there was no blood found; she could not have died of septic poison, as there was no evidence of that; it was not apparently death from shock, although that seems to me nearer the correct solution than any thing else, because, as I understand, in the *post-mortem*, no pus was found in the general cavity at all; that as the cavity was opened there existed a small amount of clear serous fluid, which did not show any evidence of general peritonitis. It is a case which teaches a good many lessons. I think probably the cause of death might have been explained if the gentleman had carried the *post-mortem* further and opened the cavity of the thorax. I am sorry that the thoracic cavity was not opened and carefully examined.

Dr. J. W. Irwin: It seems to me to be a very unique case for a person to die without any evidence that would point to the cause. It is quite possible, as Dr. Cecil has said, that if the *post-mortem* had been extended higher up the cause might have been explained. I think the only conclusion that we can come to is that the patient died of shock.

Dr. J. B. Marvin: In perforation from any cause in any cavity of the body, do you not generally have sudden death? Where there is rupture of the gall-bladder, of the appendix, gut or tube; or, if you go into the other cavity, rupture into the bronchus or thoracic cavity of an abscess, do you not as a rule have sudden death? How else can you explain these sudden deaths except by shock? The termination is too sudden to be from inflammatory or septic trouble. I think in the case reported there must have been some chronic peritonitis, or serous fluid would not have been found in the cavity, and there would not have been any distension.

Dr. Frank: No fluid was found until we got below the umbilicus. Fluid found in the lower pelvic cavity was pure pus. The adhesions in the upper part of the cavity were evidently of recent formation, as they were very easily separated, but in the lower part of the cavity they were extensive and tough and very hard to separate. I believe that there was some peritonitis, probably from contiguity of structure, and that the rupture of the tube took place twelve to twenty-four hours before death.

Dr. Cecil: In answer to Dr. Marvin's inquiry, it seems to me it is not always the history that death takes place suddenly where there is rupture into any of the cavities. I have never seen many deaths from rupture of any kind. I remember to have seen a death from perforation in typhoid fever, which I think occurred in thirty-six hours after the rupture, but was preceded by evidences of acute peritonitis, which was explained in that way, with pains referred in the ordinary classic directions. Deaths from rupture of the tubes in extra-uterine pregnancy, or rupture of pus tubes into the abdominal cavity in forty-eight or thirty-six hours are not unusual, but I take it that a death in fifteen minutes from rupture into any cavity would be very unusual. Deaths from gunshot wounds into the cavity, which would be equivalent to rupture, seldom occur suddenly, unless it be from hemorrhage.

Dr. Marvin: There must have been some change going on or it is possible the pus sac would not have dilated. There was inflammation going on without many active symptoms; at the same time there was some lowering of vitality.

Dr. Orendorf: I think death might be explained by the fact that the sudden collapse of the abscess wall in rupture caused the heart to lose its peripheral resistance, and the shock so produced was sufficient to cause death.

Dr. Wathen: I have really very little to add, more than to say that while there was no general peritonitis, and but little accumulation of pus in the free abdominal cavity,* still I was inclined to the opinion at the *post-mortem* that there had been a rupture of the great abscess cavity, and I believed that death occurred just after this rupture; and there would not necessarily be any great quantity of pus in the peritoneal cavity. With the structures matted together entirely across above the symphysis pubis it was almost impossible to tell exactly where the opening occurred, because in cutting down adhesions had to be separated after a fashion that would prevent finding the opening. I am satisfied that there was more pus in the peritoneum than was noted, and in a condition of this character, with weak, resisting, or inhibitory powers, I think a rupture of this nature might cause death within a very short time by sudden shock.

Dr. Frank: I am inclined to think she might have died of shock; this is probably the correct solution.

Dr. Marvin: In these cases, where pus forms, making an abscess sac anywhere in either of the cavities, when it does eventually rupture you are very liable to have sudden death. I do not think these cases should be compared with stab or shot wounds, as stated by Dr. Cecil. Where the formation of an abscess has been going on for quite a while there is a certain amount of toxic infection lowering the resistance and vitality of the patient, and under these circumstances rupture into the cavity is very liable to cause sudden death.

Dr. Cecil: I did not mean to convey the idea that death from rupture of an abscess cavity into the general peritoneal cavity was to be compared in all respects to trauma, that is, an acute condition like gunshot or stab wound, but more particularly to cases of the character I cited—rupture or perforation of typhoid fever; also perforations or ruptures of pus tubes, which are not so infrequent. We very seldom hear the history of cases such as have been given to-night in rupture of pus tubes. It seems to me that the only rational explanation is, that the patient referred to by Dr. Wathen died from shock. The emptying of a large quantity of pus into the general peritoneal cavity might and probably would produce great shock, and in some instances might cause immediate death; but the general observation of cases of this kind is not that of immediate death following rupture.

For instance, take cases of appendicitis: We had report of a case of death on the table, or shortly afterward, in one of the other medical

societies last week, in which when the cavity was opened it was found to be filled with pus, and the appendix was found ruptured, etc., a condition not dissimilar to the case under discussion. The patient was a chronic alcoholic subject, a man who had been drinking beer and other liquors all his life, and a man who had poor resisting powers. In that case, however, death followed many hours after perforation. That was the idea I had in regard to these cases: that I could not see why rupture of the tube in the case reported to-night should have caused immediate death, and especially since there is no history of pus in the general peritoneal cavity. A little pus in the cavity might be granted, and yet there was not, according to the report of the autopsy, very much if any pus found in the general peritoneum. Infection of the abdominal cavity could not have taken place in fifteen minutes, so it is probable, as already stated, that rupture of the tube took place some time before, and the pelvic peritoneum provided against this general infection by shutting it off, a wall or curtain being formed around the great abscess sac in the pelvic cavity, protecting the general peritoneum.

Dr. Irwin: (Pelvic Cellulitis [?].) The discussion of this case alarms me; and it occurs to me that I must be making a great mistake, or I may be eventually going to kill a young lady. I say kill, because, if I am neglecting a case, I would be responsible for her death. About four weeks ago I was called to attend a young lady, seventeen years of age, who had just menstruated. Menstruation had been normal, but afterward she was taken with very violent pains about the womb, extending clear across the pelvis and about half way up to the umbilicus, and there was a feeling of weight in the thighs, extending down the inner sides to the knees. The patient was not nervous, and the history of nervous disease in the family was wanting. There was a hectic flush on her cheeks, and considerable fever; temperature in the morning about 100° F., going up in the evening to 103° F. This condition of things had existed for five or six days. There was no discharge from the vagina, and no evidence that suppression of the menstrual function had occurred prematurely, the history being that she had menstruated for five or six days. Under the old regime we call those cases, so far as I can make out, "pelvic cellulitis." The question arose in my mind as to whether I should call in an abdominal surgeon, have the abdomen opened and the modern treatment applied, or institute the old proceedings of expectancy, so to speak, for the relief of this condition. The patient is now very much better, yet there is a good deal of soreness

and stiffness in the lower part of the abdomen, and tenderness under pressure. There is no history of a gonorrheal nature that I can discover without making an examination *per vaginam*, which I have not done, as the virginity of the patient is beyond question; consequently infection of this character is not to be considered. Her general condition seems to be improved, though tenderness still exists. She turns on the bed very badly, and when she does she has some pain, but when she remains quiet there is not much pain. There is no evidence of pus formation that I have been able to discover, and if there is pus in the abdomen, I have no idea how it could have gotten there. I believe the case will now go on to recovery, as far as recovery can be had in a case of this kind, but I am at a loss to know what brought about this trouble, unless we denominate it, as we formerly did, a catarrhal condition, not due to suppuration or infection of any kind. I would like to hear the opinion of the abdominal surgeon present as to the proper management of a case of this kind, whether it would be better to submit a patient of this age, with this sort of history, to abdominal section, or to treat her on the old plan, which we have often done, and which has often, so far as we know, cured these cases for years, until they have become mothers, and subsequently have shown no signs of disease.

DISCUSSION.

Dr. Wathen: I wish to congratulate Dr. Irwin upon the treatment of the case reported without surgical interference, for the reason that I can see no necessity for surgical interference, and such cases nearly always recover from the immediate effects without any operation. This trouble, from the entire history of the case and the history of the immediate attack, is acute. Her tubes, ovaries, and uterus were undoubtedly previously in a healthy condition, and because of exposure of some sort this local trouble began. While bacterium of some form are the prime factors in causing infection of the tubes and of the peritoneum, there may be other causes, such as exposure during the menstrual period, bringing on intense congestion or traumatic injuries; but granting that it was infectious in its origin, there is no necessity for operation, because the trouble is not sufficiently advanced to cause pus, and pus does not accumulate in tubes in this length of time; there might be salpingitis and some local pelvic peritonitis without an accumulation of pus; that would be an after-result, coming on in weeks, or months, sometimes in years. By the pathological processes familiar to

abdominal surgeons the tube becomes obstructed at the outer extremity, and finally at its inner extremity, the accumulation of pus thus becoming sacculated. But this woman may have had no pelvic peritonitis, because salpingitis of an acute character might bring on all the pain with which she suffered, and the elevation of temperature and acceleration of pulse described by Dr. Irwin. I believe that this patient will recover without an operation at any time, and shall be surprised if in the future there is any accumulation of pus in the tubes, or sufficient adhesions of the pelvic peritoneum to cause enough disease to justify a laparotomy.

Dr. Cecil: I heartily agree with what Dr. Wathen has said in regard to there being no occasion for surgical interference in this case. I believe the line of treatment pursued by Dr. Irwin is the one which is generally recognized as being correct and proper. I might ask if there is not a possibility of gonorrheal infection.

Dr. Frank: I believe in all these cases there is a possibility of accidental infection. I do not mean by this infection from coitus, but there is danger of infection from one member of the family to another, and this has recently been illustrated in an article written by a German investigator in the *Centralblatt für Bact. u. Parasiten-Kunde*. In this article there are quite a number of cases reported of children ranging from four to fourteen years of age, every one of which suffered from vaginitis. An examination proved that in every case the gonococci were found. It was finally ascertained that infection had occurred from one of the older girls having gonorrhea, the children all using the same bath tub, the same towels, some of the same linen, the infection had spread from one child to the other. If this is the case, and we have no reason to doubt it, I think that it is quite possible for all of these cases of vaginitis in young children to arise from gonorrheal infection. Later it has also been shown that specific organisms, such as the staphylococcus pyogenus aureus, may exist in a perfectly healthy vagina without causing any trouble whatever. These organisms may also spread to the uterus and tubes and give rise to pus tubes. As for myself, I believe that nearly all pus tubes are due to specific infection. We may not be able in all these cases, however, to demonstrate the existence of the specific organism, because it is known that organisms die out on any media in which they may be growing, provided this media is by their continued growth rendered unfit.

Dr. Bloom: Concerning accidental infection; as a case in point: A

child, five years old, was brought to me suffering from what seemed to be simple vaginitis; no examination was made for the gonococcus, because gonorrhea was not suspected. The history of the case was that the child had been with her grandmother for two or three weeks, and there she had noticed a slight discharge from the vagina of mucopurulent material; she developed a severe ophthalmia two weeks after her return. An oculist was called in, and upon examination pronounced the trouble gonorrheal ophthalmia. All history of gonorrheal contact was denied by both the parents of the child and the grandparents; but accidentally the oculist discovered in a drug store a prescription for a nitrate of silver solution to be used as an injection by the father, who had denied any history of gonorrhea. Seven or eight weeks after I first saw the child the father consulted me with the remains of a clap. Had it not been for the accidental discovery of the prescription in the drug store, it is probable that I should never have suspected any thing more than simple vaginitis. I do not believe that a clear differentiation between simple and specific vaginitis has been demonstrated clinically in young children.

Dr. Irwin: I have very little to add in closing. The possibility of infection in this case is very remote indeed; if such a thing could occur it would be almost miraculous. So far as the treatment is concerned, thus far it seems to have been successful in relieving the trouble, and I hope the good results will continue until she is finally restored to health. I am gratified to see that the gentlemen who have spoken on the subject agree with me in the management of the case. I have had a number of cases of this kind in former years, before the question of abdominal surgery for the relief of such conditions was spoken of very much, and I believe with fairly good results. In a great many cases permanent recovery resulted, while in a few the results were not permanent, and I have no doubt some of them before this time have lost the tubes, ovaries, or womb.

T. C. EVANS, M. D., *Secretary.*

TYPHUS FEVER.—The number of cases of typhus fever and of deaths in New York has considerably diminished, although new cases are still reported almost every day. The Board of Health has recently been successful in securing through its counsel the conviction of six lodging-house keepers for allowing their places to be overcrowded.

CINCINNATI OBSTETRICAL SOCIETY.

The Cincinnati Obstetrical Society at its annual meeting was very "Hospitably entertained" at the Private of Dr. T. A. Reamy. The election of officers resulted as follows: President, Dr. William H. Taylor, Vice-President, Dr. J. M. Witherow, Secretary, Dr. E. S. McKee.

A move is on foot to consolidate all the medical societies of Cincinnati under one society.

Rigidity of the Os Uteri was the subject of a paper read before the Obstetrical Society of Cincinnati by Dr. E. W. Mitchell. He considered the finger useful at times, but thought extreme care necessary that this means does not produce or, if present, increase spasm of the muscular fibers. The colpeurynter is much more efficient and safe where mechanical dilatation is called for. Electricity deserved much more attention as a powerful uterine stimulant than it received. He has found quinine to increase the uterine contractions notably. He finds chloroform advantageous even in the first stage, where it is generally considered inadmissible. When other measures fail, incisions in the rigid os may be made. They should be made under antiseptic precautions, and need not be deep, one fourth to one sixth inch.

Dr. Palmer: I am in the habit of trying to frame in my mind the differential diagnosis in every case of rigid cervix, and as to whether it is functional or organic. I think one can do this. Of course, if there is an organic lesion there is an organic disturbance, but there is usually a functional disturbance without organic change. These rigid uteri usually exist in nervous women who can not bear much pain, and the cervix becomes rigid, labor is delayed, and the uterus does not act properly, because there is an improper development of the muscles of the body. In these cases, where pregnancy follows, I generally depend upon three remedies: First, hot water vaginal injections. I think a douche of this character makes the parts more soft and also tends to relaxation of the rigid cervix. I was in the habit of administering chloral, and then gelsemium in five- or six-drop doses every half hour or hour, but I finally settled down to the use of chloroform, and for the last ten years have depended almost exclusively on chloroform in the first stage of labor. Having used the vaginal douche, I do not use chloral, but sometimes morphia or atropia in hypodermic injections, and I have found them to do good in some instances. If this does not do, I administer chloroform by inhalation, more frequently in the first stage than in the second stage of labor. I sometimes give it until the production of partial anesthesia, and I have not had a case of this kind where it did not cause speedy relaxation of the cervix. By these remedies I have been enabled to control these rigid cervices. I have not made incision of the cervix. A case happened with me a good many years ago in which there was considerable organic change. This case was in

consultation, and we waited hour after hour and the cervix still remained rigid. I took a pair of long scissors and cut it in several places, and it finally relaxed. That is the only one in which I have employed any mechanical means. I consider chloroform by inhalation the best remedy.

Dr. Byron Stanton: I agree most fully with the essayist, especially in giving preference to chloral over chloroform in the relief of difficulties in the first stage of labor. I very seldom use chloroform in the first stage, but reserve it for the second stage. I have used warm injections, and occasionally injections of morphia, but usually only when the pains were weak, and were exhausting the patient without accomplishing much. I have generally been agreeably surprised afterward, when the uterine contractions returned, by the rapidity with which dilatation was effected. I believe morphine acts indirectly by giving the patient rest, and after this dilatation is more rapid. I have never resorted to surgical means for relieving this condition, for I have never seen a case which seemed to call for this treatment. I think the difficulty is very often caused by some malposition of the fetus, which, if it can be removed, will assist in the delivery. Very frequently it is due to rupture of the membranes, and in this case, if some presenting part will act in the same mechanical way as the bag of waters, the dilatation will be effected more rapidly. The cases in which I have experienced the most trouble are those of malposition, and in a recent case, a breech presentation, the patient was in labor many hours before the breech could come down. In this case chloral alone was used, and chloroform not used until complete dilatation. The forceps were first applied to the breech, and afterward to the head. I have not tried belladonna or the injection of opium in these cases.

Dr. Edwin Rickets: When doing obstetrical work I made it a rule to give chloroform whenever the patient was suffering to any great extent, whatever stage of labor the patient was in, and I have had many a rigid os to yield when putting the patient under chloroform. In my earlier work I gave chloral, but I have been better satisfied with the use of chloroform. I have given chloroform two hundred and fifty or three hundred times, and I never saw any bad effect to the mother or child.

The Role of the Pessary in the Cure of Retro-displacements of the Uterus was the subject of a paper read before the Obstetrical Society of Cincinnati by Dr. Sigmar Stark. In this paper the doctor made the claim that backward displacements of uterus were cured by the pessary through the induction of an inflammatory state in these ligaments.

Dr. Palmer: We all must realize that this is an important subject. It requires a very good judgment to know when to use and when not to use a pessary. I believe that pessaries are out of fashion nowadays, but when I commenced practice pessaries were in fashion. I think I used a pessary twenty-five times more frequently fifteen years ago than I do to-day. Nevertheless I am by no means prejudiced against the use of them, but I believe that now pessaries can largely be dispensed with. I don't believe

that we need them nearly so frequently as we formerly did. Displacement of the uterus, whether downward, forward, backward, or even upward, is not really a disease, but only a secondary condition. I think Dr. Thomas was the first man who enunciated this principle of practice, and with his usual clearness and force. He stated that all displacements are dependent upon four causes: First, increased bulk and weight, causing the uterus to descend or become displaced forward or backward; second, relaxation of support; third, increased pressure from above, and fourth, increased traction from below. Always it will depend upon one or more of these factors. No one would think of attempting to treat a uterus displaced because of relaxation in support, or increased weight from above, or increased traction from below, by the methods useful for the relief of displacement caused by increased bulk and weight. We should rectify as far as we can any of the etiological factors, and having done that, I am disposed to think that most displacements of the uterus, including posterior displacements of course, will be relieved of their morbid symptoms. In almost all displacements of the uterus, there is an error in the circulation, as well as an error in place, and it is this error in circulation that creates the symptoms, as well as the error in place. How many times have we seen this morbid condition, and how often we have seen complete displacement without any complaint whatsoever. I do not know but that retroversion is just as common as prolapsus, for we never have retroversion without prolapsus, as we never have prolapsus without retroversion. Mechanically they go together. A pessary should not be used until the anterior conditions creating or coexisting have been corrected as far as practicable. If there are adhesions, of course they are to be modified or removed.

There is another method of treatment of which I desire to speak, and that is the use of the faradic current. I think the faradic current is a potent factor in the treatment of some of these cases of displacement of the uterus. Remove all anterior conditions as far as practicable and then replace the uterus, aided, it may be, by a proper electrode, and with the latter in position, retaining the uterus *in situ*, we utilize the primary faradic current, with the negative pole placed in the posterior vaginal cul-de-sac, unless there are menstrual objections, and the other pole on the abdomen. Thus the current will pass through the sacro-uterine ligaments, as well as through the recto-uterine ligaments, and through the uterus itself. I believe we seldom have these conditions unless there is some pain felt in the uterus, and generally there is a bulk in weight as well as a relaxation of support. Generally pessaries relieve for the time being, and as soon as withdrawn the uterus falls back again into its faulty posture. Then they become palliative only, and not curative. Exceptionally, however, they are curative.

Dr. Sigmar Stark: I did not attempt in the paper this evening to thoroughly discuss the subject presented, but only to bring out one point, mentioned by Dr. Reamy: Whether the influence exercised by the pessary

was due to its pressure upon the sacro-uterine ligament, and the consequent inflammation induced in it. In speaking of the pathology I only touched on the relaxation of the sacro-uterine ligaments, and spoke of this as being due to a posterior perimetritis and a subinvolution of the muscular fibers in these folds. Possibly, as I mentioned, the massage treatment might induce a cure, as might the treatment mentioned by Dr. Palmer, the faradic current, benefit the patient. Dr. Reamy is inclined to hold to one of the earlier principles which I enunciated in my paper, viz., considering the retro-displacements as due to a faulty state of all the tissues contributing to the supporting power. By that I mean to include the suction force produced by the diaphragm. The sacro-uterine ligament is the main one to prevent retroversion, and is the main ligament, and I believe attempts to restore the sacro-uterine ligament to a normal state will bring about a better result than attempts upon other tissues.

There is no question in my mind but the round ligaments have a great influence in that direction, but I do not believe their influence is to be compared with the influence of the sacro-uterine ligaments. The operations upon the round ligaments have done nicely for a time, but I do not think their influence has been permanent. The operations recently advised are too recent to have stood the test. I have tried to explain the influence of the pessary upon the sacro-uterine ligaments as being due to the same causes we are now trying to bring about by operative procedure. I have tried shortening the uterine ligaments, not by the method advocated by Alexander, but I tried to sew in the round ligaments during the whole course of the canal. In a case upon which I operated in this way recently, using silk sutures, one side has suppurated. The patient says she feels perfectly well, but I have not examined her since. I have also tried the abdominal hysteropexiation, stitching the uterus to the peritoneum, so as to secure a union with the parietal peritoneum. Another method is the Wiley operation, in which Dr. Zinke assisted me. Instead of taking in the fold of the round ligaments alone, I took in a fold, after first scraping, of the lateral ligament as far as I could go. This seems to me to play quite a rôle. I do not deny that other tissues have an influence in supporting the uterus in its position, but the sacro-uterine ligament is the main agent.

In acute and subacute inflammations the amount of inflammatory infiltration seriously interferes with the nutrition of the part, and naturally this condition is followed by atrophy and also loss of elasticity of the part, but in chronic condition of the parts we have really developed a state resembling a callous condition. The parts are being rubbed upon all the time. Nutrition is stimulated, and for that reason the volume of the ligaments is increased, and their strength is increased.

E. S. MCKEE, *Secretary.*

Reviews and Bibliography.

On the Chemistry and Therapeutics of Uric-Acid Gravel and Gout: Being the Croonian Lectures for 1892, delivered before the Royal College of Physicians of London, with additions. By WILLIAM ROBERTS, M. D., F. R. S. 136 pp. London: Smith, Elder & Co. 1892.

On all matters of clinical chemistry it is everywhere conceded there is no better guide than Sir William Roberts. Bringing to bear his vast attainments on urinary chemistry to the special features embraced in this work, he could not fail to illuminate it with increased brilliancy. The most novel feature of the author's views is that in which he attempts to show that uric acid, as found so pestilently productive of concretions in the mammalian urinary organs, is the result of changes in the quadriurates which compose the urinary sediment found at times in the urine. This, he claims, is the homologue of the quadriurates that compose the solid urine of birds and reptiles, and its formation constitutes a true functional rudiment. This amorphous deposit, the author shows, is maintained in its harmless state largely by the pigment or coloring matters of the urine, though neither coloring matter nor salines will serve to protect against deposits among the gouty and very high livers.

Dr. Roberts shows also that there is no direct relation between gout and stone: In some regions where gout is abundant stone is rare, and in others where stone is abundant gout is rare. The treatment of the various conditions presents nothing new, only that when such an author speaks one may be sure that he is certain of his position, and that he has proved and stamped with his authority what otherwise might be more or less vague and uncertain. Both for its method and its matter this little book, like every line perhaps the author in his maturer years has written, will well repay a careful study.

D. T. S.

History of the Life of D. Hays Agnew, M. D., LL. D. By J. HOWE ADAMS, M. D. With fourteen full-page portraits and other illustrations. In one large royal octavo volume of 376 pages; extra cloth, beveled edges, \$2.50 net; half morocco-gilt top, \$3.50 net. Sold only by subscription. Philadelphia: The F. A. Davis Company. 1893.

This is a loving tribute by a devoted friend to a great and good man. With kindly disposition the life of the illustrious surgeon and his distinguished lineage are traced from a date preceding the Norman conquest. The impartial reader will, however, perhaps not be able to see as great future fame for Dr. Agnew as does his friendly biographer. That he was a man of broad views, of knightly bearing, of loving and lovable disposition, and of such skill as an operator that dying he left perhaps no equal in America, if in the world, we may well believe.

It does not appear, however, that he was an intense thinker, and while he readily caught all the important points of a subject in their salient proportions, leading him to a judgment quick and almost unerring, he lacked in the power of invention, and hence has not contributed a large share to the productive thought of the age. As an evidence of the laxness of his investigations outside of his chosen field may be quoted a sentence from his address before the American Surgical Association, an address which, according to his biographer, authorities declare ought to be found in every household in America. "I have no especial taste," says Dr. Agnew, "for exploring museums of bizarre collections. Indeed, without a key to interpret the curious and ingenious mechanisms for clothing the form divine, such an exploration would be like an archeologist attempting Egyptology ignorant of cuneiform inscriptions." As the cuneiform inscription was known only to the Chaldean and ancient Persian languages, and could not have been more helpful to the Egyptologist than the Runic or Chinese alphabet, it is to be suspected that the lesson in archeology came on the good doctor's "busy day." But, withal, the spirit and the life of Dr. Agnew's labors still remain, and will remain in the lives and labors of myriads, even though his original contributions to surgery were not of such a character as to mark an epoch and to give to his fame a separate and distinct prominence. His fortunate association with the treatment of the wounded President Garfield will do more than any thing else to present his name to future times as pre-eminent in surgical skill, as holding a most exalted, but not envied, place in the hearts and minds of the medical profession and of the American people.

D. T. S.

International Clinics: A Quarterly of Clinical Lectures on Medicine, Neurology, Pediatrics, Surgery, Gynecology, Ophthalmology, Laryngology, Otolaryngology, and Dermatology by Professors and Lecturers in the leading Medical Colleges in the United States, Great Britain, and Canada. Edited by JOHN M. KEATING, M. D., I.L. D., JUDSON DALAND, M. D., J. MITCHELL BRUCE, M. D., F. R. C. P., London, and DAVID W. FINLAY, M. D., F. R. C. P., Aberdeen, Scotland. Vol. xiv. 387 pp. Philadelphia: J. B. Lippincott Company. 1893.

In a recent number we reviewed the first three volumes of this series, and took occasion to speak of them in the high terms they appeared to deserve. The fourth volume is even an improvement in the way of impressive teaching. Space does not admit of separate discussion of the various lectures, but a single reference will be made to certain doctrines advanced in the first lecture by Dr. James Tyson in regard to the cause of hypertrophy of the heart in disease of the kidneys. Dr. Tyson, after reviewing the various theories, advances the new one, that the heart is overworked in order to compensate for the loss of functioning substance in the kidneys, and this results in hypertrophy. But how is the heart driven to this overwork? Do the damaged parts of the kidneys call for it? Do the healthy parts desire to do more work than usual and call for it? Or whence comes the complaint that drives the heart to this excessive work to its own

great damage? In our opinion Bright himself virtually gave the answer, only it lacked a little in elaboration. The noxious matter retained in the blood causes the arterioles to contract, and the tissues thus deprived of the proper quantity and quality of blood for their nutrition, complaining to the nerve centers, compel the heart by reflex nerve influence to overwork. Why does the heart of a pregnant woman or one suffering from anemia hypertrophy, unless in this way? As well say that the air rushes into the sound lung in pneumonia because the other is not doing its duty, as to say that the heart overtasks itself simply because a part of the kidney is lost, and without any circle of causative forces.

D. T. S.

The Chronic Disorders of the Digestive Tube. By W. W. VAN VALZAH, A. M., M. D., formerly Demonstrator of Clinical Medicine, Jefferson Medical College. 151 pp. New York: J. H. Vail & Co. 1893.

This book, with the exception of the chapter on Habitual Constipation, the author tells us, is made up of communications to the Journal of the American Association, the New York Medical Journal, and the New York Record. Originally intended for serial publication, no very great changes have been found necessary to adapt it to the present form. We regret to feel constrained to say that it would, in our opinion, have been much to the interest of the reader if these changes had been greater, especially in the way of concentration and conciseness. There are too many platitudes, too much of seemingly irrelevant comment, too much of repetition. Little objection can be made to the author's teachings, they are all fairly orthodox. But a new book should either set forth a subject better than others or give something new in order to justify its appearance. This work, in our opinion, does neither.

D. T. S.

Diseases in Children. Manual for Students and Practitioners. By JAMES CAR-MICHAEL, M. D., F. R. C. P. (Ed.). Illustrated with thirty-one charts. 591 pp. New York: D. Appleton & Company. 1892.

In writing this manual the author claims to have endeavored to give a concise account of the clinical features of the more common diseases met with in children. He has assumed that the reader is acquainted with general medicine and the diseases of adult life. This assumption is in many places put to the test. In the study of quite a number of diseases the reader would gather a very superficial knowledge from these pages, if he were not already acquainted with the diseases of adult life from clinical experience and use of more elaborate text-books. However, the author has faithfully fulfilled his promise, and carried out his undertaking of trying to show how the anatomical and physiological characteristics of the periods of infancy and childhood tend to modify in many ways the features and clinical relations of the diseases of children. The method is direct, the language well chosen and explicit, the style smooth, and yet impressive, furnishing a book of easy and pleasant reading. It is one of the best of the manuals.

D. T. S.

Foreign Correspondence.

LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

Professor Virchow; Infant Mortality in Liverpool; A Distressing Accident; Dr. Savage on Mental Dissolution; High Mortality on Public Works; Dr. Sophia Jex-Blake; The Growth of the Medical Profession; Forthcoming Conversazione at the College of Surgeons.

Professor Rudolph Virchow has received the honorary degree of Doctor of Science at Cambridge, Dr. Sandys, the public orator, introducing him as the Rector Magnificus of the Berlin University, and referring to his services to medicine and the public health, and to his reputation as an anthropologist and ethnologist. Professor Virchow met an enthusiastic reception.

A paper on "Excessive Infant Mortality in Liverpool, Its Causes and Prevention," jointly written by Dr. Hugh R. Jones and M. Herbert E. Davies, was read a day or two ago to the Local Literary and Philosophical Society. The authors, after explaining that by Liverpool municipal Liverpool was meant, and by "infants" children under one year of age, stated that while the infant mortality for the whole of England for the ten years from 1881 to 1890 was 142 per 1,000 births, the rate in Liverpool during the same period was 183, being an excess of 41 per 1,000 births. The average number of children born annually in Liverpool exceeded 19,000, so that more than 7,700 infants died in those ten years who would have lived if they had enjoyed the average chance of life which prevailed throughout England and Wales. As to the causes of the excessive infant mortality in Liverpool, that from zymotics might be ascribed to density of population; that from lung diseases to overcrowding and attendant insanitary conditions; from diarrhea, atrophy, debility and privation, to ignorance and neglect, while the excess from violence explained itself. Liverpool was notoriously the most overcrowded city in England, the population numbering 99 per acre, or 115 if the docks were excluded. Of every 1,000 children born in Liverpool, 9 died in infancy by violent means, whereas the rate of all England was only 3. Dr. Jones also stated that Liverpool was the most drunken city in England.

A most unfortunate incident has occurred in the operating theater of a large London hospital. One of the staff, while sewing up the wound after a laparotomy, gave a flourish to the needle in his hand, which entered the eye of a dresser who was assisting him. The latter after a few moments was compelled to leave his duties owing to the pain in the eye and sit down on a chair. The operation being complete, the surgeon turned and exam-

ined the sufferer's eye, and found to his amazement that the lens was lying outside the organ, the sclerotic extremity torn and the vitreous protruding.

Dr. Savage recently read a most interesting paper on "The Symptoms of Mental Dissolution." He excluded all tables relating to patients over fifty years of age, as such cases only showed the way in which senile dissolution occurred. Dr. Savage said that his seventeen years' experience at Bethlehem showed that dissolution was early shown by loss of power of acquisition, then by loss of power of retention of recent impressions, next by defect of co-ordination, and last of all by loss of control and of judgment. Although, generally speaking, dissolution was the reverse of evolution, it did not follow exactly the same lines. He first treated of dissolution as seen in general paralysis of the insane, passing on to consider disorders of control of a general kind, such as hysteria, epilepsy, mania, melancholia, and dementia, taking the groups of symptoms before the individual ones, and particularly noting the danger of impulse in the maniacal, suicidal and melancholic states. Of the individual symptoms loss of recent memory, varying in degree and kind, was the most important. Loss of emotional control was next in frequency, and was most important as leading to sexual faults. He was unable quite to understand the disregard of cleanliness in such cases. Judgment often remained practically unimpaired long after the memory had visibly weakened. Referring to the recurrence of epileptic fits in elderly persons which were formerly looked upon as of grave import, they were now known to be curable by rest, quiet, and diet.

A letter to the Prime Minister and the Home Secretary draws attention to the startling death-roll due to accidents at public works. During the construction of the Manchester ship canal 12,000 men were engaged in addition to the employment of about 500 excavators, steam navvies, etc.; during the first year occupied in carrying out the work it appears no fewer than between 1,000 and 1,100 fatal accidents occurred, 1,700 men were permanently injured, while 2,500 were partially disabled, so that in five years on one undertaking no fewer than 5,000 men out of 12,000 met with accidents, and it was necessary to have these special hospitals for their accommodation. It is pointed out that this is not an isolated instance, as during the construction of the Tilbury docks 100 men lost their lives.

Dr. Sophia Jex-Blake, Dean of the Edinburgh School of Medicine for Women, says that the struggle for the medical education of women that began in Edinburgh in 1869, and has lasted almost a quarter of a century, has just ended in a victory all along the line. For seven years medical education has been provided for women in the Edinburgh school, and clinical instruction in Leith Hospital, and the lectures of the conjoint Scottish Colleges of Physicians and Surgeons have also been open to women, but hitherto the medical degrees of a university have been denied them. So far as Edinburgh University is concerned this exclusion still holds, but the University of St. Andrews has thrown open its gates, and now with pride Dr. Jex-Blake says "our students are entitled to matriculate as its under grad-

uates and to present themselves for its medical degrees." Those who have studied elsewhere can qualify for St. Andrews by two years spent at the Edinburgh school.

At the annual meeting of the National Health Society it was stated that the proposed cholera hospital on the Thames, near Blackfriars, would be a danger, cholera being a water-borne disease. Another member of the Society, who had watched its growth during twenty years, spoke of the daily increasing interest shown by the masses in all matters relating to health and sanitation.

It appears that the growth of the medical profession, according to the last published Medical Register, was rapid during 1892, no fewer than 1,513 newly qualified medical practitioners were added as against 1,345 in 1891. The statistics were commenced in 1876, and the past year shows the greatest number of names added to the ranks of qualified practitioners. The highest previous total was 1,531 in 1887. In 1876 there were 22,200 medical men registered; at present there are 30,590. The average mortality annually has been 560, and the average annual removal, 834. The increase has taken place in all the three kingdoms. The number registered in 1892 in England was 749 as against 863 in 1891, and an average for the previous five years of 669; in Scotland 581 against 502, and an average of 487; Ireland 183 against 160, and an average of 166. On the other hand the Medical Students Register shows a decided decrease in the number of students, the number being 167 in 1892, which appears to be lower than in any year since 1876, and 734 less than 1891.

The conversazione to be held at the Royal College of Surgeons on July 5, 1893, to celebrate the jubilee of the Fellowship of the college, promises to be a most interesting event, as it happens also to be the centenary of the death of John Hunter. An exhibition is being organized of pictures, MSS., books, furniture, etc., connected with the celebrated surgeon. The present proprietors of various relics have promised to lend their trophies for the occasion.

LONDON, March, 1893.

THE TREATMENT OF INOPERABLE MALIGNANT NEOPLASMS BY THE BICHLORIDE OF MERCURY IN OIL.—Mr. R. Cowan Lees has used a solution of bichloride of mercury in olive oil in the strength of 1 to 2,000, injecting twenty minims by means of a hypodermatic syringe provided with a solid-pointed needle having several orifices at the side of it, thereby allowing the mixture to diffuse through the tissue of the tumor, and affording less danger of its being thrown into the circulation. The surface of the skin is previously cleansed with a solution of this oil, 1 to 1,000, with twelve per cent of menthol. From his observation of three cases he believes that a powerful check, if not a complete remedy, exists in this method of applying the bichloride.—*The Lancet*.

Abstracts and Selections.

THE FRENCH TREATMENT OF ANGINA PECTORIS.—M. Huchard, in an abstract in the *Gazette des Hôpitaux* from his recently published work, directs attention to the importance of distinguishing between true (coronary) angina and pseudo-angina, which, associated by the presence in both of neuralgia of the cardiac nerves, are separated by the occurrence, in the true form only, of ischemia of the myocardium. M. Huchard considers the treatment of angina pectoris under four heads.

1. *Preventive Treatment.* Here we must combat the tendency to high arterial tension, and attend to hygienic methods, particularly diet. Treatment must likewise be directed against aortitis and arterio-sclerosis by the use of milk and of iodides and nitroglycerine. On account of the tendency of aortitis to narrow the coronary orifices, and thus to hamper the nutrition of the cardiac muscle, we must endeavor to diminish the work of the heart, attending especially to the peripheral vessels. Treatment to this end by means of the iodides is all important. The iodide of potassium is given in doses of fifteen grains three times daily. As loss of appetite, epigastric pain, and diarrhea may arise, it is well to give the drug for twenty to twenty-five days only in each month, nitroglycerine in small doses being prescribed in the intervals.

2. *Curative Treatment of the Attacks.* Under this heading we may prescribe amyl nitrite by inhalation, or nitroglycerine in one-tenth grain doses, three or four times daily, for a period of seven or fourteen days. On account of the tendency of nitrite of sodium to change hemoglobin into methemoglobin, it is not looked upon with favor. Morphine produces increased cardiac action and passive dilatation of peripheral arteries, with consequent lowering of pulse tension, besides exerting a sedative and analgesic effect. By combining the nitrites with morphine, good results are often obtained; and if the nitrites fail, one third of a grain of morphine hypodermically is of great value.

3. With respect to the treatment of *complications*, renal insufficiency and cardio-sclerosis appear during the periods of freedom from anginal attacks. Cardiac dilatation of paresis and syncope are due to the influence of the attacks. Heart tonics, especially digitalis, are indicated in cardio-sclerosis and cardio-paresis. For renal insufficiency we must favor depuration of the blood, and suppress all kinds of food liable to the formation of ptomaines. Caffeine, ether, or nitroglycerine, injected subcutaneously, is advised in syncope.

4. M. Huchard refers, lastly, to useless or dangerous methods. Such are electricity and cocaine, bleeding, bromides, hypnotics, inhalations of

oxygen, belladonna, and aconite. Briefly, therefore, we must combat pain, direct treatment alike against arterio-sclerosis, the development of which leads to degeneration of the cardiac tissue, and against lesions of the coronary arteries, and, above all, against cardiac ischemia, which is the "chief and only danger" in this affection, and thus we should at a very early date, when signs of arterio-sclerosis appear, even in the absence of anginal symptoms, commence the iodide treatment.—*The Medical Chronicle ; The London Practitioner.*

DISINFECTION IN CHOLERA.—Borntrager (*Deutsche Medicinische Wochenschrift*, 1892, No. 40,) suggests the use of dry heat in the disinfection of clothes and other articles contaminated with cholera. He admits that for ordinary purposes of disinfection this agent has been shown to be impracticable, owing to the high degree of dry heat necessary to kill the majority of the infectious micro-organisms, and because dry heat has comparatively limited power of penetrating the articles to be disinfected. For cholera, however, he considers it exceedingly well adapted because of its simplicity, and he believes it also to be amply efficient on account of the vulnerability of the cholera bacillus to moderate heat and drying. An exposure of a few moments only to a dry heat of 100° C. is sufficient to kill the cholera bacillus. Borntrager therefore suggests that in time of emergency ordinary brick ovens, which may be quickly built, afford all that is really necessary for the disinfection of bedding, clothes, etc. The temperature should be kept above 100° C., and the articles to be disinfected should be loosely laid in the oven and exposed to this temperature for from one to two hours.

Such an oven was extemporized during the past summer by Borntrager in Sulingen, where he is health officer, and was used with success in the disinfection of the clothes of persons coming from Hamburg and Bremen.—*American Journal Medical Sciences.*

ACUTE MIGRATORY OTITIS.—Dr. Szenes, of Budapest, proposes the term "acute migratory otitis media" for a class of inflammatory diseases of the middle ear. He has seen three instances in which one side is first affected, and about three days after complete recovery the middle ear of the opposite side. This migration or metastasis is not easily accounted for, but it may be analogous to the somewhat rare migratory form of pneumonia, where a small portion of the lung is first attacked and after its recovery another and perhaps distant and larger portion becomes affected. In the first case of migratory otitis seen by Dr. Szenes the left ear was first attacked, the process becoming suppurative. When the inflammation appeared in the right ear energetic measures, as local blood-letting and cold compresses, were successfully employed to prevent suppuration. In the second case there was no suppuration either in the right ear, which was the one first attacked, or in the left. In the third case there was suppuration on both sides.—*London Lancet.*

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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THE KENTUCKY STATE MEDICAL SOCIETY.

The thirty-eighth annual meeting of the Kentucky State Medical Society will be held at Frankfort on the 10th, 11th, and 12th of the current month. The central position, the popularity of the presiding officer, and the reviving interest in the Society throughout the State give earnest of an unusually large attendance. The programme is an exceptionally full one and covers a wide range of practical questions.

Adequate preparations have been made by the good people of the Capital to entertain the guests of the occasion, and all are expecting a good time and a profitable meeting.

The American Practitioner and News has made arrangements to publish the papers to be read, and nearly all of them may be expected to appear in the near future in its columns.

WHY NOT ADVERTISE?

The question of advertising on the part of physicians has come to the front again, and is exercising the talents of various editors. Secular papers also seem to be taking a lively interest in the subject, as with reason they might do, in view of the advantage the general practice of advertising on the part of physicians might bring them.

It really seems not easy for the general public to understand why doctors may not as well advertise their skill as for merchants to advertise their wares, and doctors themselves often place it upon no higher grounds than that the Code of Ethics forbids it. If the thing is really right and desirable, to the waste-basket or the ash-barrel with the Code of Ethics say we, unhesitatingly. But is it right; is it desirable? Perhaps there is no better way to examine a question than to analyze it and reduce it to its underlying principles.

Proceeding in this way we find two grounds upon which may be based objections to advertising on the part of physicians. The first of these is deference to the views of those around us, deference to custom. In the organization of society there is a mutual concession and compromise whereby each tacitly agrees to do certain things and to forego certain things, agreeable and perhaps profitable to himself, as they happen to appear pleasant or unpleasant to his neighbors and associates. And the man proves the degree of his culture, if not the goodness of his heart, by this deference to the feelings and even prejudices of others.

The history of the past is that this deference has been excessive, and the breaking of customs and habits of society that have become old tyrants has amounted to a cataclysm, while the agent in the destruction has too often found himself a martyr.

But in the matter in question, custom having so little hold on the emotions is entitled to but little more than "I beg your pardon" as we tramp on its toes.

The second reason for a restraint of advertising lies in the interests of the public, and is founded on the general lack of qualifications to judge of the abilities of the doctor. My hatter may advertise the best bargains in hats to be had on the continent, "bankrupt sale," "a perfect slaughter of prices," and much more of the same kind; but if I take the trouble to make him show me several standard brands that I may compare with those of other merchants, I may soon know whether his statements are false or true. So with nearly every line of goods. Even if deceived at the time the wearing will tell the tale, and the next time I can avoid him. In the mean time I am not so greatly hurt. The goods have answered their purpose for a while, and I have not irrevocably lost most precious time.

But it is not so in advertising in medicine. Here the public can not judge of the value and fitness of the remedies given, otherwise they would not need the doctor. It follows, then, that they are open always

to deception. The modest man will be backward about publishing his own notions of his ability. The really learned doctor understands enough of human nature to know that if he were to boast he would be hated. Only the fool is allowed to boast. But, above all, the truthful man could state things only as they might actually exist. The empty liar would therefore have the whole field to himself. It has been insisted that these empty braggarts soon fade into obscurity and dishonor, and that only good men have enduring success. This is true of all extreme cases; but unfortunately a new crop is always coming on, and one passing into disgrace and contempt but makes room for another, and yet all the while the modest, straightforward, capable man is left in obscurity. But it is not so true that the sins of all those who strain the Code of Ethics in stealthily advertising meet with such recompense; and men grown gray in success in almost every city show that irregularities of this kind, if not too glaring, do not react to the destruction or even disgrace of their authors.

But what shall be the limit, where shall the line be drawn in the matter of advertising? Reason would clearly teach that whatever a man may tell his neighbor about himself he may put in the papers. The difference in kind is nothing, there is only a difference in degree. That quackery is penetrating the ranks of the profession there is no denying, and seemingly it is in the saddle to stay. Is there no other remedy than to meet the enemy on his chosen ground after giving him choice of weapons? To us there seems to be one at least, and may be even more than one. First, we may band together, and through the public press as such organizations enlighten the public as to why we do not advertise. In the second place, we may raise the standard of qualifications so high, by requiring a thorough course of study and a rigid examination, that men will prize too highly what they have thus so hardly attained to be willing to drag it in the mire.

SOME PROSPECTIVE BIOGRAPHICAL NOTICES.

An enterprising secular journal of this city has been collecting notes of the lives and business history of a number of physicians with a view to having them appear in a "World's Fair" mammoth edition.

Type-written copies of these notes, written up in biographical form,

have been shown to several of the subjects of them, and the result has been something surprising. The number of Hippocrateses, Galens, Sydenhams, etc., found among our local practitioners could scarcely be less a source of astonishment than any single sight of the great fair itself. Notwithstanding the gaudy colors in which these unwilling candidates for historiographical honors have been arrayed, the subjects of them are not all as yet satisfied; and it is said some of them were at last accounts burning the midnight oil in getting up "biographies" more to their liking. As among them are a few good hands at the bellows, something exceptionally "breezy" may be expected. One of the leading medical societies, the Medico-Chirurgical, at its last meeting passed a resolution binding all its members to observe the Code of Ethics in any publication that may be permitted.

Notes and Queries.

Editors of the American Practitioner and News:

CINCINNATI CORRESPONDENCE.—Cincinnati has been called upon to mourn the loss of two of her most worthy citizens on the same day and within a few hours of each other, Drs. Dawson and Davis.

Dr. William W. Dawson was born in Virginia, December 19, 1828. His father removed to near Xenia, Ohio, when the doctor was but two years old. He graduated in the Medical College of Ohio in 1850. From 1860 to 1864 he was Professor of Anatomy in the Medical College of Ohio, and from 1864 to 1870 lectured on clinical surgery in the Cincinnati Hospital. In 1870 the doctor was elected to fill the chair of Surgery in the Medical College of Ohio, vacated by the late Dr. Blackman. This chair he filled with distinction till 1887, when, on account of failing health, he resigned, when the chair of Clinical Surgery was made for him, and he continued Professor of Clinical Surgery, lecturing at the Good Samaritan Hospital till disabled for service one year before his death. Dr. Dawson was for several years Dean of the Faculty of the Medical College of Ohio. The greater part of his illness he spent in the Good Samaritan Hospital, where he had served as surgeon since 1871, and where he had relieved many a poor sufferer by that art which failed to relieve him. Dr. Dawson served as President of the Cincinnati Academy of Medicine, Ohio State Medical Society, and of the American Medical Association—elected at the Cincinnati meeting and serving at the Newport meeting. Dr. Dawson waited many years for patients in Cincinnati, but patients have also for many years waited for

him. His offices have been crowded with the sick of this and surrounding cities. Dr. Dawson was much interested in the welfare of the Cincinnati University and the S. P. C. A. work. He died without family, having had no children, and his wife having died some years before.

Dr. William B. Davis was born in Cincinnati, July 2, 1832. He graduated from the Miami and Ohio Medical Colleges of this city. He served two years as surgeon of the 137th O. V. I., during the war. For fifteen years he was Professor of Materia Medica and Therapeutics in the Miami Medical College. Dr. Davis was for a number of years trustee of the Cincinnati Hospital, member of the local, State, and National Medical Societies, one of the founders of the Public Library and first directors of the University, one of the prime movers and for many years chief medical examiner of the Union Central Life Insurance Company of Cincinnati. He leaves a wife and two sons, Dr. Clark W. Davis and Mr. William L. Davis, both of this city.

E. S. M'KEE, M. D.

THE CANCER PARASITE.—The *Lancet* thus comments on Dr. Galloway's recent delivery on this subject: Dr. James Galloway's lecture on the Parasitism of Protozoa in Carcinoma should serve a useful purpose if it does nothing more than divert into a new line the thoughts of those who, looking upon cancer as an incurable and unpreventable disease, have adopted a stereotyped formula. Passing lightly over the form of epithelial proliferation found in the rabbit's liver as the result of the action of coccidia, and putting aside for a time the very interesting facts regarding indirect infection, which themselves are worthy of deep study, Dr. Galloway, after most careful investigation, corroborates the fact that a great deal of confusion has existed and still exists as to the nature of various bodies contained within cells. He points out that many authors have described as parasites objects which demonstrably have nothing to do with parasitism, and he insists on a careful discrimination being made between organic parasites and bodies which are merely the result of degeneration or irregular development in the cells. This is a very important step, and will save many future observers the trouble of contending against theories that have no foundation in fact and observations that can not be corroborated by independent workers.

The more important of the false parasitic bodies he considers may be classified under five headings: (1) Partial invagination of one cell within another; (2) leucocytes within epithelial cells, especially in secondary cancerous deposits in lymphatic glands and toward the margins of rapidly infiltrating growths; (3) endogenous formation of cells; (4) irregular mitosis; and (5) various degenerations, such as colloid, "keratinous" or irregular breaking up of the chromatin. There are others no doubt, but all the above forms have been described at some time or other as parasitic bodies. It is impossible, however, for any one, he says—and in this he is supported by Soudakewitch, Ruffer, and Walker—to mistake any of these bodies for the true parasite.

Dr. Galloway very wisely refrains from expressing any very definite opinion as to what part these parasitic protozoa play in the etiology of cancer. He describes their position in the tumor and in the cells; their relation to the body of the cell and to the nucleus; he shows in what points they differ from and in what they resemble the parasites found in the adenoma of the liver of the rabbit. He does not ignore the difficulties that surround the proof that must be forthcoming before these protozoa can be accepted as playing any definite etiological part in the production of cancer, and he leaves each of his readers, after laying before him a very careful and accurate description of the only bodies yet found which show any real evidence of their parasitic nature, to form his own opinion. Dr. Galloway agrees with Metchnikoff in the fact that they are distinctly foreign bodies within the epithelial cells, that their appearance is essentially that of an organized structure, that their staining reactions are perfectly distinct from those presented by the normal cell contents, and that their behavior within the cells resembles that of certain other parasitic organisms in the lower animals—"all point forcibly to the conclusion that these bodies, though not necessarily coccidia, are nevertheless protozoa and are parasitic in cancerous epithelium." We have, then, an accentuation of the fact that something new has been found in cancer, and a further step has been made in the direction of the goal of the surgeon's desire. Some hope is afforded that we are within reach of a knowledge of the etiology of cancer; when this knowledge is obtained, and not till then, there may be a reasonable prospect of treating cancer successfully, first of all directly, and secondly by prophylaxis, the latter promising a much more successful field of operation than the former. It will not do, however, to be too easily led away in this matter, for we may anticipate that past experience will be repeated, and that before long these parasitic protozoa will be found, or will be supposed to be found, in all sorts and conditions of tumors.

Special Notices.

The usefulness of GOOD Hypophosphites in Pulmonary and Strumous affections is generally agreed upon by the Profession.

We commend to the notice of our readers the advertisement on page — of this number. "ROBINSON'S HYPOPHOSPHITES," also "ROBINSON'S HYPOPHOSPHITES WITH WILD CHERRY BARK" (this is a new combination and will be found very valuable) are elegant and uniformly active preparations; the presence in them of Quinine, Strychnine, Iron, etc., adding highly to their tonic value.

DR. BREITBACH, OF BADKRENSCHA, DRESDEN, GERMANY, November 17, 1892, says: I have tried BROMIDIA in a case of Insomnia, caused by severe neuralgia, and the result was most satisfactory. Before I prescribed this preparation the patient always asked for injections of Morphia, but never afterwards. I think that BROMIDIA will be of great service in cases where one wants to wean a patient from the habit of taking Morphia. I shall certainly continue to prescribe the preparation.

THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNĀ."

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NO. 10.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

LEPTOTHRIX MYCOSIS OF THE TONSIL, PHARYNX, AND BASE OF TONGUE.*

BY WILLIAM CHEATHAM, M. D.

Professor of Diseases of the Eye, Ear, Throat, and Nose, Louisville Medical College.

B. Frankel, of Berlin, in 1873 pointed out the presence of leptothrix threads in an affection of the tonsils, base of tongue, etc., which had before been known as follicular inflammation of these parts. Some authors have since gone so far as to say that they are one and the same disease; that they all contain the leptothrix threads. I feel assured they are two entirely different diseases; that the presence of follicular tonsillitis makes one more liable to have mycosis of the part, as leptothrix threads are present in most of our mouths most of the time. In follicular disease of the tonsils there is more constitutional disturbance; the contents of the lacunæ is yellow and easily detached. The microscope shows the absence of leptothrix threads. The deposits are scarcely ever above the level of the tonsil surface. I have taken a syringe in a case of chronic follicular tonsillitis, passed the tip into the openings in the tonsil and washed out dozens of small lumps of secretion which have a disagreeable odor. These deposits are within the lacunæ and the tonsils are usually enlarged; the disease is curable; in many cases it responds to treatment readily. These symptoms do not hold good in all cases.

In mycosis leptothricia of the tonsils, the tonsils are usually small; usually so small you can not get hold of them with a tonsillotome to

*Read before the Louisville Medico-Chirurgical Society, April 7, 1893. For discussion see page 382.

remove them; there is no constitutional disturbance; no bad odor; patients complain of foreign bodies such as hair, fish-bones, and splinters of tooth-picks being in their throats. The deposits are white or yellowish white; most always very difficult to detach; frequently can not be even curetted away; have to, in a majority of cases, be torn off with forceps; are elevated above the surface of the tonsils; sometimes pedunculated; often look like small spurs; are frequently located, not in the crypts, but away from them; may be on the pillars of the fauces. The microscope shows numerous leptothrix threads present. Jaksch says "these threads are long bacilli, usually segmented and arranged in large ribbon-like bundles; they stain bluish-red in iodine-potassic-iodide solution. Shorter bacilli are sometimes present which do not stain."

O. Chiari says he considers it a modification of follicular angina, and that yellowish plugs which do not contain leptothrix are often found in the crypts of the tonsils. Ingalls, in his late work on "Diseases of the Chest, Throat, and Nasal Cavity," page 369, says "mycosis of the throat is a parasitic disease of the tonsils and upper portion of the throat, characterized by yellowish-white deposits resembling in some cases those of follicular tonsillitis." It will be observed that Dr. Ingalls believes in the duality of the affection. On pages 370 and 371 he gives side by side the points in the differentiation of the two affections. In the New York Medical Journal of December 3, 1892, F. I. Knight, of Boston, publishes a paper on this subject that he read before the American Laryngological Association. This same journal also contains the discussion of the paper by Drs. Delavan, De Blois, Johnston, Mulhall, and others. Wright, Mulhall, Beverly, Robinson, and Langmaid, in fact a majority of those present, appeared to believe in the duality of the affection; the others gave no opinion on this point.

Dr. Knight says, in his article, that "in the April, 1882, number of the Archives of Laryngology, Dr. Emil Gruening, of New York, published an article (without any allusion to the previous publications of Frankel) which began thus: 'While the constant presence of leptothrix elements in the mucus of the mouth and the frequent occurrence of concretions in the tonsillar crypts are facts with which every medical man is conversant, the relation existing between leptothrix buccalis and the formation of tonsillar concretions does not seem to have been recognized even by the throat specialist.'"

From an examination of fifty cases Gruening advanced the proposition that all tonsillar concretions were composed of leptothrix elements,

and that the calcification of these masses might be induced by the presence of the alga leptothrix, just as the presence of certain non-parasitic algæ in liquids containing salts of calcium in solution induces a precipitation of the calcium in the form of a carbonate. He further says that "the presence of these concretions in tonsillar crypts and carious teeth is merely a substantiation of the more general fact that leptothrix concretions will form in all these normal and pathological recesses of the mouth and pharynx which are not reached by the ordinary process of cleansing, remain undisturbed by any mechanical action during the processes of mastication and deglutition, and are devoid of any secretory *vis a tergo* sufficiently potent to dislodge the parasite."

"This is a strong statement of the case by one of those who believe that the parasite is the *fons et origo malis*."

"It would, however, seem reasonable to classify those cases in which the growth has become excessive, and is rapidly reproduced again and again on removal, as cases of mycosis, whatever the exact mode of origin; and although it is difficult, as stated by Newcomb, to say just where the process ceases to be a natural accident and becomes a pathological entity, the typical cases of tough, adherent, spear-like, projecting masses can be set down as cases of mycosis, but the less marked cases will be hard to classify."

I have just seen a most typical case of so-called chronic follicular tonsillitis with deposits on the base of the tongue, also with no leptothrix threads.

Four or five years ago I had under my observation two healthy school girls, with tonsils very small, in fact almost no tonsils at all. Yet what remained of them was studded with hook-like deposits of leptothrix. These deposits were not only on the tonsils but over the base of the tongue, the pharynx, and the faucial pillars; the curette was used, and all kinds of applications made, with a rapid return of the deposits. Both cases were finally relieved by stopping all sweets, and giving the alimentary tract the correct attention.

March 3d, Mrs. R. was sent to me by two Indiana physicians. She had had for several years an affection of the throat, with sensations of hair or fish-bones in the throat. Her family being tuberculous, her friends and physicians were much alarmed concerning her. She presented a most typical leptothrix mycosis of pharynx, faucial pillars, tonsils, and base of tongue. Those on the base of the tongue were flatter and larger than those on the other parts. Plate xxxvi in Dr. Robert

Krieg's Atlas of Diseases of the Throat, etc., gives a splendid picture of the disease as seen in Mrs. R.'s case. I had considerable difficulty in getting enough of the deposit off (as it was so adherent) for a mount for the microscope. The microscope showed the threads of the leptothrix to be very plentiful. Mrs. R.'s throat at times gives her no trouble, as the disease occasionally gets well of itself—to return again in weeks, months, or years.

Leptothrix mycosis of the throat is very difficult to cure. The teeth should be investigated, for there you may find a nidus for the parasite. This is said to assist in the production of tartar and decay of the teeth. The deposits should be removed, if possible, by forceps or the curette, or, still better, a galvano-cautery point should be inserted into each deposit, applying it to several each day, and making the applications not too close together. This treatment is slow, painful, and tedious. Cocaine will of course prevent the pain. This treatment gives the best results.

Again, all foods (such as sweets) which are liable to ferment in the alimentary canal should be stopped, and the canal kept as aseptic as possible. Sometimes the disease disappears, as I stated before, without treatment; again, no treatment does any good; then again, calomel internally with the alkalies and salol and naphthaline may make a cure; but it is well in a genuine case of mycosis leptothrix pharyngea not to make any promises of permanent relief. Cases may hang on for years, and pass from physician to physician, yet get no benefit.

LOUISVILLE.

CHLOROFORM ANESTHESIA AND ADMINISTRATION.*

BY P. GUNTERMANN, M. D.

Means to subdue pain in operation have been used since the earliest days of medicine and surgery. Dioscorides, 50 A. D., used a decoction of mandragora; others used the different kinds of narcotics; others used spiritous liquors and made their patients drunk. In 1844 Dr. Horace Wells, of Hartford, Conn., pulled a tooth for a patient under the influence of nitrous oxide, long before discovered by Sir Humphrey Davy. In 1846 Dr. Morton, of Boston, did the same, but used sulphuric

*Read before the Louisville Clinical Society, April 4, 1893. For discussion see page 388.

ether as the anesthetic; in the same year Dr. Warren, also of Boston, did the first surgical operation on a patient under the influence of ether. Sir James Simpson, in 1847, was the first to use chloroform. His brilliant success in this first, and thousands of other cases, soon established chloroform as the almost universal anesthetic. It was by preference used the world over, except in the eastern States of the United States. To this anesthetic agent, "chloroform," if you will bear with me, I will call your attention to-night.

In years gone by it was necessary for the anesthetist to make the test for purity of the article he was to use. His chloroform must be pure—it must be colorless, it must leave no odor or stain after evaporation, it must not discolor on being shaken with sulphuric acid and water, must not give chloride precipitation with nitrate of silver. To-day these tests are no longer necessary. All chemists can easily furnish the pure article, and the only possible adulterant, alcohol, is absolutely harmless.

I may be pardoned for making this short and imperfect resumé of the history of anesthetics in general and chloroform in particular, and we will now proceed with the main question at issue. In order to be more precise and permit an easy and quick survey, I will bring the subject under these four leading questions, viz :

1. Who shall give chloroform ?
2. To whom may and shall it be given ?
3. How must it be given ?
4. How much is to be given, and how does it affect the patient ?

The first question, who shall give chloroform? In this age of specialties, the supposition is near that I would unqualifiedly suggest a specialist, a man who makes it his business to give anesthetics, and gives this business his undivided attention. Not so. I maintain that every qualified physician ought to make it his business to be ready for the occasion and to be well versed in the details of anesthetization. No man who has not mastered these details has the moral right to handle an agent at once so great and powerful for good or evil. One ought to think twice before he takes the balance of life of a fellow creature in hand, a scale so delicately poised that the quiver of a muscle may sink the lethal side. Nor is this all. Every death that happens during the administration of chloroform is promptly ascribed to it. The clamoring mob abuses the unhappy administrator, and, denouncing the agent as dangerous, robs many a poor sufferer of this great boon to humanity.

Rarely ought a doctor now-a-days to be placed in a position to be an anesthetist and operator at the same time; yet all of us may be placed in this very unpleasant predicament. In such a case only the most urgent and absolute necessity can be at all excused. The anesthetist ought to give all his attention to his charge, and not for one moment ought he to attend to the operation; if he does, he may find to his sorrow that the patient needs his attention no longer.

The next question is: To whom may and shall chloroform be given? Before we give chloroform to any one he should be properly prepared, that is to say, his physical condition ought to be made as favorable for the taking of this powerful drug as can conveniently be done. The person to be chloroformed ought not to have a full stomach, that is, he ought not to have eaten solid food for at least six hours before he is to take chloroform. Nor is it well that the patient, perhaps nervous, excited, or exhausted from illness and suffering, becomes weak from prolonged fasting. It is therefore advisable to give a cup of broth or some fluid food a couple of hours preceding the administration of chloroform. Sometimes it is well to give stimulants.

The individuality of the patient is not so material. Chloroform may be given with impunity to the baby a few days old and to the centenarian. Babies and young children bear it remarkably well. The intermittent pulse is no contra-indication.

Bright's disease, valvular disturbances of the heart, even fatty degeneration of that organ form no absolute barrier. However, it is well to inquire into all these possible conditions, and when present they should put us on our guard and make us all the more cautious and attentive. After the patient has fairly recovered from the influence of chloroform, it may be well to give some stimulant, sometimes a little morphine hypodermatically. This induces a few hours rest or sleep from which there is usually a refreshed awakening.

The question, how shall we give chloroform? is one of vast importance. The first thing to decide is, by what means the agent is to be administered. Many an apparatus has been invented, Clover's, Snow's, etc., but none of them has stood the test of practical experience. If they were perfect dosimeters, they were impracticable and unwieldy; if they were manageable machines, they had no value save the maker's price, and did not better serve the purpose than the napkin and towels of Sir James Simpson. Only in a regular operating room is a complicated apparatus practicable. Nothing is handier and better than

a cone made of a napkin covered by paper. Such a cone answers every purpose. With it we can regulate the dose, the proper admixture of air, and reduce waste by evaporation to a minimum.

Stand behind the patient at the head, notice the condition of countenance and pulse, and place your finger for convenience on the temporal artery. Encourage, reassure, cheer your patient, and go to work. Pour into the cone about a dram of chloroform, bring it gradually to the patient's face and let him breathe from the cone with a large allowance of air. Approach gradually, and as soon as the sensibility of the air-passages is overcome, as evinced by the subsidence of coughing or swallowing, give chloroform freely almost to the exclusion of air. Continue in this manner until your patient breathes easily and the eyelids no longer wink when touched. Now the patient is ready for most all operations. To bring him into this state takes from two to six minutes.

Your patient is your only care. Keep the finger on the pulse and watch with eye and ear the state of respiration. Be ready to state instantly rate and quality of pulse. If the patient's manner becomes excited, withdraw the chloroform; if his countenance becomes livid, give sparingly and much diluted, since often rapid and deep inspirations follow this state and enhance the danger by adding rapid anesthesia to asphyxia. We must bear in mind the accumulative tendency of chloroform. Desist from giving chloroform when the patient vomits, at least if you be not sure that his stomach is empty and free from solid food. Be certain that your patient breathes and that air enters into the lungs; diaphragmatic movements may deceive you. As soon as you hear laryngeal stertor stop the chloroform.

The nature of the operation must determine how far your patient is to be anesthetized. Watch unremittingly the sensibility of the conjunctiva and the condition of the pupil, whether or not it responds to light. If the pupil does not respond at all be extremely watchful and be ready to give timely warning, but also be careful to give no false alarm. In operations on the genito-urinary apparatus, and on the rectum, we find in the condition of the pupil the best indication whether the patient is sufficiently narcotized; he must be profoundly under the influence of chloroform. In case your patient becomes weak and faints, as shown by pallor, profuse perspiration, and yawning, leave off chloroform, put him in the hyper-recumbent posture with his head lower than his hips, and order some stimulants. Quickly withdraw the chloroform when you perceive laryngeal stertor, pull the chin forward, upward, and

with it the head backward. This maneuver removes (or may remove) the obstruction in the larynx and raises the ribs and sternum, in fact is an easy and gentle form of artificial respiration. When this method does not succeed, turn the patient on his side and institute artificial respiration after Marshall Hall or Silvester. It may become necessary to pull out the tongue, which has fallen back and over the epiglottis. This ought to be done with a pair of sharp forceps, using a deal of force, not to say violence, in order to excite reflex action.

In extremely dangerous or disastrous cases quite a number of means for resuscitation are to be used to avert the fatal issue; but of these later on.

The last of our questions, how much is to be given, and how does it affect the patient? remains to be answered. The quantity to be used in a given case depends on the nature of the operation and the probable time it takes to do it, and much more and perhaps wholly on the nature, temperament, and habits of the individual. Nervous people, hysterical women, and those addicted to the excessive use of liquor require a larger amount of chloroform than those that are differently or normally constituted.

Children, while they bear it well, require a great deal. I have seen patients thoroughly anesthetized for two hours, using only one ounce of chloroform, while others in that length of time took as much as 10 to 12 ounces. No two people, however, are affected alike. A person before an operation, let it be ever so trivial, is naturally somewhat nervous, shows signs of discomfort. Some are excited, pucker their mouths, pinch their eyes, screw and twist in all sorts of manner.

The first effect of anesthesia is loss of this nervousness and restraint. The eyes are generally opened, the patient looks around and talks, often quite rationally about the operation, etc. The conversation gradually becomes incoherent, often boisterous; some laugh and sing, some pray and curse. Now some muscular movements may be observed, followed by a struggle requiring forcible restraint. This is followed by a state of muscular rigidity which subsides gradually or abruptly. There is a little muttering succeeded by a drunken sleep, with complete relaxation of all the voluntary muscles and abolition of sensibility. This is complete anesthesia. Absence of insensibility in the conjunctiva and insensibility of the pupil to light give accurate information as to the true condition of the patient. Sometimes, more in children than in adults, the sphincters relax and the contents of the bowels and bladder are voided invol-

untarily. Such a state of affairs indicates some danger, and solicits an extra degree of watchfulness lest the heart and respiratory muscles become involved in the same way.

Under the influence of chloroform the pulse becomes first accelerated, it gradually gets less frequent, and finally resumes the normal tempo. It may become slow and weak as the operation progresses. The condition of the pulse may be greatly influenced by loss of blood during surgical procedure.

Together with the pulse goes respiration. Respiration, too, first becomes quickened, gradually returns to normal (even full and deep), and then may become superficial and shallow. As hinted before, movements of the chest are no assurance that respiration is properly going on, of which fact we can easily convince ourselves by listening; do not not always trust to the eye alone.

You recollect the laryngeal stertor spoken of. There is another kind of stertor, the palatal stertor. Palatal stertor is no more nor less than ordinary snoring, familiar to all. It is nearly always the warning signal that the patient is chloroformed enough. It is no sign of danger, but marks the border line of safety. The laryngeal stertor, with which we all have become acquainted in other conditions than those produced by anesthesia, is of the greatest moment. It is presumably, perhaps positively demonstrated the result of closure of the larynx by paralysis of the epiglottis and a falling of the relaxed arytenoid folds on the rima glottidis, and possibly a relaxed condition of the vocal chords. If this condition persist, death from asphyxia is the inevitable result.

Death from chloroform either comes gradually or suddenly. What may be the causes, and how to counteract them, I will not now discuss, but reserve for some future day.

LOUISVILLE.

ENURESIS DIURNA.*

BY F. C. SIMPSON, M. D.

I bring before the Society, to-night, "Enuresis Diurna," a disease that gives us a great deal of trouble to treat with satisfaction. I have, in the past four years, come in contact with quite a number of cases of day-wetting, and one or two I have failed to treat with as much satisfaction as I would like. I have tried any number of drugs, and failed

* Read before the Louisville Medico-Chirurgical Society, April 7, 1893. For discussion, see p. 378.

to get relief for the poor, unfortunate little fellows. You have one of the most frequent causes in tight prepuces, which keep the glans bathed in smegma, and then the glans macerates, and sets up an irritation that results in the incontinence. Yet when you stretch the prepuce or circumcise you find the children afflicted with the same trouble that they had before the operation was performed. We have certain nervous troubles that seem to play a very important factor in the little fellows' trouble; and when you relieve the nervous trouble the child continues to wet his clothes just as before. You have the distressed mother appealing to you to do something that will relieve her afflicted child of such an obnoxious habit, and you take lists of drugs and prescribe them in rotation to find that you have failed to do what you may have promised to do.

I do not suppose there is a member of this Society who has not had just such experience as I have related, and finally given the cold comfort to the mother by saying the child would outgrow it as maturity was approached. Can we afford to allow the child to wait so long with such a disgusting habit? I say not. I can only say that the child who is not relieved by the ordinary drugs has a cause for his incontinence that is worse than the incontinence, and that is masturbation; and you will find when you treat him for masturbation that he gets well. You must keep a close watch on him, for he is so sly, and will repeat the act as soon as the blisters heal. You must have complete control over your patient or you do him no good. If you make close inquiry of the mother, you will find that she frequently catches the child rubbing the parts, and this results in an erection, and immediately you find the little fellow has made water. He is unconscious of the desire until he finds that his water is trickling down his leg and his clothes are wet. You find that the majority of these patients play with the parts. The question of masturbation is becoming quite a serious one for the physician to cope with, and experience brings this question up quite often during the year.

You may have muscular debility of the neck of the bladder, or the internal sphincter is sometimes a part of the muscular incompetency which is found among different classes of children. Dr. Jacobi speaks of masturbation as not an uncommon cause of incontinence of urine. In his paper on Masturbation in Childhood he has directed the attention of the profession to the frequency of the habit of masturbation, with all its consequences. In the young the caput gallinaginis is quite large, as

are also Cowper's glands, and the prostatic folds sufficiently developed to result in erections. The constant irritation of the parts by self-abuse leads to a chronic inflammation of the whole prostatic portion of the urethra and the neck of the bladder, which is very sensitive.

My experience with these cases is that I find this condition to occur in children from five to eight years of age. I speak only of that class that are free from the trouble at night, and suffer during their waking hours. I have found tight prepuces in two cases, and they were circumcised with relief, as long as the wound did not heal, and as soon as the parts were well why they would return to their old habits. In both cases I blistered along the dorsum of the penis and down on the perineum. I found, as long as I kept the blister from healing, that they did not suffer from the incontinence and for some time afterward before they had any return, and then they began their old habits of playing with the parts and the incontinence returned with the same regularity as before the blistering. I had to repeat the blisters on one three and the other four times before I controlled the trouble, and as it is now four months since either one has suffered from any trouble of that character. I do not question in either of these cases but the cause of the incontinence was masturbation. And I based my belief upon the fact that the mothers of both these boys would catch them playing with the parts, and almost immediately following they wet their clothes, and one mother told me that she found the little fellow frequently with an erection when she caught him playing with the parts. You find that these children are exceedingly nervous little fellows. They have loss of appetite, seem to be debilitated, and show some mental hebetude.

In regard to treatment, will say that I have gone all the way down the list, and find in these intractable cases that you can not do any thing for them, except the frequent blistering, and it must be persisted in until you give them relief. I have the first case in which to see it fail, while circumcision, atropia, *rhus aromaticus*, and all the drugs that are said to do good, in a great number of these cases, fail signally in giving more than temporary relief.

LOUISVILLE.

Reports of Societies.

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.*

Stated Meeting, April 7, 1893, Dr. F. C. Simpson, President, in the chair.

Dr. W. O. Roberts: (Uterine Polyp.) Day before yesterday a lady sent her husband to my office to ask me to send her a pessary to hold up her uterus, which was out of place. The woman is fifty-two years of age, very large and fleshy; never had any children. Of course I told the husband that I could not do any thing of that kind without first examining the case very thoroughly. He sent for me to-day. I found, sticking out of the vulva about a half inch, a polyp that seemed to be about as large as my thumb. The pedicle extended up into the neck of the uterus. I removed the growth after ligating the pedicle, and present the specimen here for your examination. She thought it was her womb sticking out. It is a mistake that we all are inclined to laugh at, that the woman should take the polyp for a prolapsed uterus.

It calls to my mind a case which I had sometime ago. A young woman who had been a widow for several years consulted me, and said that she had not had her period for a little over six weeks. Shortly after that I was sent for and found her flooding. By digital examination I found what I took to be the membranes protruding. I grasped the mass firmly with my fingers and tried to pull it out, but it would not come. I inserted a tampon to stop the hemorrhage, and the next day I found the substance protruding still further. I made a more careful examination, and discovered that instead of a miscarriage it was a polyp trying to get out of the uterus. The woman was having regular labor pains, and I felt satisfied at first that it was a miscarriage.

Dr. J. G. Cecil: (Enlargement of Cervix during Pregnancy.) Dr. Roberts' remarks recall to mind a case that I saw last year at the University clinic. While it was not a polyp, it was one of those peculiar freaks of nature which we sometimes meet, and which keeps us guessing as to what it is for a while, perhaps. It was an enormous enlargement of the cervix with the woman pregnant at the same time, pregnant five months. The cervix was so enormously elongated and enlarged

*Stenographically reported by C. C. Mapes.

that it had prolapsed so that there was a tumor resting outside the vulva fully as large as a man's fist. At first I thought it was a sub-mucous fibroid which had been extruded by contraction of the uterus and was being retained by the pedicle. An examination of the part that was resting on the vulva revealed a hole in the lower part of it which would easily admit the full length of the finger. I then introduced a sound into this opening very carefully, not suspecting at the time that the woman was pregnant, when, much to my surprise, the sound entered seven or eight inches. Then I began to think it could not be a fibroid, because no fibroid would give the appearance of this tumor with a central opening in it of this depth. The tumor was very much ulcerated, discharging a foul pus. She was walking about with this prolapsed cervix outside. I replaced it by putting her in the knee-chest position and greasing the tumor with vaseline thoroughly, then making pressure upon it, reducing it in size until it slipped back. I then applied a tampon and sent her to the hospital. Perhaps it is well to say that up to this time I had not made up my mind fully as to the nature of this tumor, because I could easily discover a tumor above which had specially the appearance of the womb, and I could also ascertain a direct connection between this tumor, which was outside the vulva and the womb, and I could probe it to the depth of seven or eight inches. I was really somewhat puzzled as to what it could possibly be. After it was retained in position for a while, and had subsided very much in size, an abortion came on, which demonstrated the fact that the woman had been pregnant for five or six months, that the child had been dead for probably a week or more, very much macerated and decomposed. It was a very peculiar case, and one that might easily be mistaken for almost any thing, but which, under the conservative treatment, watching it and waiting for developments as to what it could be, turned out very well for all parties concerned. It is simply one of those oddities which we occasionally meet in shape of tumors coming from the vagina, resting in the vagina, or being directly connected with it. I understand that she remained about the usual length of time at the hospital, and was discharged cured, but in all probability there was an enormous enlargement of the neck which ought to have been amputated.

Dr. W. L. Rodman: (Tuberculous Knee-Joint; Amputation.) This specimen was taken from a young man twenty-seven years of age, who gave the history of tuberculous disease of the knee-joint covering the space

of eighteen or twenty years. He was brought to me by Dr. Peyton, of Jeffersonville, Ind.; and after examining the limb very carefully I noticed that there was at least two to two and a half inches shortening of that leg, and altogether it looked like a very unfavorable case for resection. Still I sent him to the Norton Infirmary with the full understanding on his part that a resection would be done, and if the bone was found to be involved to any great extent we would amputate his leg at about the lower third of the thigh. An incision was made and the joint resected, and, as expected, we found a large abscess cavity in the inner condyle of the tibia, and also one in the inner condyle of the femur. These abscess cavities extended deeply into the bones. The one in the inner depression of the tibia extended down to the medullary canal, communicating with it; the one in the femur extending up at least one inch and a half. I was assisted in the operation by Drs. Peyton and Skinner, and we all decided at once that it would be jeopardizing the patient's life to an unwarranted extent to attempt resection, and even if we had succeeded in saving his life we could not have given him a useful limb, so the member was removed just above the knee. I simply wished to present the specimen to show the abscess cavities in the lower end of the femur and upper end of the tibia. Resections of the knee-joint do not do any too well at the best, and I think any thing else but amputation in this case was out of the question. There were a number of fistulous openings, two or three of which were discharging at the time. A sufficient number of instruments were put out at the beginning, so that nothing was used in the amputation that had been used in the resection. The patient has done very well since the operation, eight days ago.

DISCUSSION.

Dr. C. Skinner: I saw the case with Dr. Rodman before the operation, and had the pleasure of seeing the operation performed. There were two or three features in the case that to my mind opposed the theory of resection: In the first place, the poor limb that you get at that age, and the risk you run in any resection; further, the extreme shortness of the tibia made it unreasonable to suppose that a good limb would be obtained by resection. Although the man was twenty-seven years of age, he had a tibia of about nine or ten years. There was at least two and a half to three inches shortening of that limb previous to any resection, which would have made the shortening at least four inches after resection. Artificial limbs are being so well made now that

I think they are of more service than limbs as short as this one would have been after resection. We were a little surprised at the depth of the abscess cavities in the bone at the time of the operation, but were not at all surprised to find the accumulation of pus.

I think the doctor's idea of discarding all the instruments used in the resection and using fresh instruments for the amputation is a good one. I followed out the same plan in an operation of similar character at the City Hospital some weeks since. There was union by first intention, and no trouble has been experienced since.

DISCUSSION.

Dr. Roberts: I operated on a case something similar to this a few days before Dr. Rodman operated. The patient was a young lady in this city who has had suppurative disease of the joint since childhood. The tibia in her case was nearly four inches shorter than that of the other side, still she has been able to be around with the aid of two canes. I simply did an amputation without making any attempt to do a resection. In the case operated upon by Dr. Rodman I do not see any other course that could have been pursued except the one stated by him. I do not think it is necessary to attempt in these cases to save the limb, especially where the bone has become involved to the extent that this specimen shows. Resections as a rule do not do any good where it is necessary to take off much bone. In young subjects of course we are very careful not to do resections where there is disease of the bone itself, because if we take off much bone the limb ceases to grow. Although this man had probably gotten his growth, owing to the extent of the bone involvement there was really no other course to pursue except amputation.

I operated upon a man at the Norton Infirmary last fall, a patient sixty years of age, who had an osteo-myelitis. After sawing off the bone twice I still found the medullary canal diseased, and with a spoon I scraped it out clear up to the upper end of the bone, then introduced a drainage-tube, and he got along beautifully, and now has a stump on which he can use an artificial limb.

Dr. A. M. Vance: (Cholecystotomy.) Nine days ago I was called to see a woman fifty-seven years of age, with the statement that Dr. Dugan had been called the day before and had told her that she had appendicitis. I made a careful examination of the woman and came to the same conclusion. There was quite a tumor in the region of the appen-

dix, extending well down into the pelvis, very sensitive, particularly at a point midway between the anterior superior spinous process of the ilium and the umbilicus. She gave the history of having had a similar attack about a month before. I advised her to go to the Norton Infirmary at once and have an operation performed. I made an incision in the region of the appendix, and came immediately upon a tumor that looked something like the kidney, but as I had only gone through one layer of peritoneum I knew it could not well be the kidney. Upon further investigation I came to the conclusion that it was the gall-bladder, which I aspirated, removing quite a quantity of muco-purulent material (flaky), and possibly some pus in it. I then opened the gall-bladder, after packing around thoroughly with gauze to prevent the cavity being entered by any of this material, and removed five gall-stones at once, and pressed my finger high up in the enlarged gall-bladder and dislodged this very large stone, which was fastened in the cystic duct, it being removed with considerable difficulty. The gall-bladder was carefully stitched to abdominal wall, the cavity of gall-bladder being packed with gauze, and the woman has made a good recovery.

I will state that there was very little discharge for the first three days; then there was free discharge of bile, entirely relieving the pain which she complained of in the region of the liver. This case proves how many things may occur in the abdomen, and how parts can be shifted from one locality to another. I remember Dr. Dugan operated upon a similar case sometime ago at the Norton Infirmary, removing an enormous quantity of gall-stones from the cavity.

DISCUSSION.

Dr. Roberts: Were you able to examine the liver?

Dr. Vance: Yes. The liver seemed to be in a perfectly healthy condition.

Dr. Vance: (Microcephalus; Operation.) I would like to mention another case I operated upon yesterday for Dr. Barbour. The patient was a microcephalic child two years of age, which I saw first when it was a little less than six months old. Ossification of the skull seemed to be perfect then, and the child seemed to be very peculiar, having each day a number of epileptic seizures or spasms, and I gave it as my opinion then that the child would probably be an imbecile. It has gone on for two years maintaining its physical condition completely, but showing no signs of intelligence whatever. I took it to be a typ-

ical case for the operation of craniectomy, and the parents were very anxious to have the operation done, having investigated the case thoroughly, having been to Chicago and other points for the purpose of discussing the question with other surgeons. Yesterday I made a section of the skull. The child bore the operation wonderfully well. Operation done very quickly, being finished and dressed in twenty minutes. I present here the bone removed, and several instruments which have been devised by different surgeons for doing this work. I first made an incision in the scalp; then with a trephine took out a small button from the frontal bone, just above the sinus, afterward making a section to the occiput with the bone forceps, which I present here with the specimens. Hemorrhage very slight. The child is in good condition to-night. It had some little reaction yesterday, temperature going up to 103° F., shortly afterward quieting down to 100° F. There now seems to be much less evidence of nervous irritability, and the muscular movements which were invariably present are greatly improved. The mother thinks there is quite a good deal of difference in its manner, etc., but I do not know whether she imagines this or not. It is the second time I have done the operation, the first being a child nine years of age, a typical case of microcephalus. Child died seven hours after operation.

DISCUSSION.

Dr. Wm. Cheatham: The patient referred to by Dr. Vance was brought to me sometime ago for examination of its eyes. The child was very restless and fretful, having spasms, etc., and it was very difficult to make any diagnosis. However, I discovered that there was atrophy of both optic nerves.

Dr. Vance: The eye symptoms have disappeared since the operation. I saw the child two days before the operation was performed, and there were no evidences of intelligence. I passed bright objects like my watch before its eyes, but no attention was paid to it. Since the operation the eyes will follow my watch when passed before them, and the eyes are perfectly steady. Certainly some change has taken place, but what the final outcome will be it is hard to say.

Dr. Rodman: I think Dr. Vance acted very wisely in operating upon only one side in this case; that is, at one sitting. I heard Dr. Keene express himself very freely upon this subject about a year ago; saw him do one operation of the kind upon a patient six or seven years old.

He referred to the operation as done by Dr. Wyeth, which is to operate upon both sides at one sitting; then the fingers are inserted in each opening and the bones spread apart forcibly. Keene thinks there is too great amount of shock when both sides are operated upon at once. He has never done the double operation. The case I saw him operate upon in the Jefferson Hospital a year ago never had a bad symptom, leaving the hospital in about a week. He, however, expressed very little confidence that the operation would do any good. It was not a very promising case for operation.

Dr. A. M. Cartledge: (Fistula in Ano; Operation.) I simply present this patient to show one feature that is a little remarkable. It is the most extensive fistula in ano that I have ever known to get entirely well under one operation. There must have been in all twenty-eight inches of fistulous tract dissected up. The patient is about fifty-five years of age, and says that he first began to have trouble with the rectum about nineteen years ago; operation performed about a year ago. You will notice one fistula extended across the perineum to the scrotum, and several in other directions. Only one went into the bowel. There were evidences of lung infiltration, and he was placed upon hypophosphites and cod-liver oil, and now seems to be in very good health. He was under treatment about three months.

The essay was read by Dr. F. C. Simpson; subject, Enuresis Diurna. [See p. 369.]

DISCUSSION.

Dr. Palmer: The subject of masturbation in childhood has received a great deal of attention of late years, and very deservedly so; and all physicians who come in contact with such cases should strive, if possible, to classify them, to relegate the patient to that class to which he distinctly belongs. A masturbator at five years would most necessarily fall into the class of "congenital onanism." A child who is instructed by playfellows in onanism, it will be found from examination of authorities on the subject, is rarely so instructed before his eighth year, while it is very common for them to be instructed by their playmates, nurses, etc., anywhere from eight to thirteen or fourteen years. A child may inherit a pathological condition of the nervous system that tends to produce congenital masturbation, and may become a masturbator almost immediately after birth; but this classification should be with a view of determining the management of the case. I think those of you who will study the works of Von Kraft Ebbing on the subject

of psychopathia sexualis will be surprised at the remarkable uniformity of cerebral abnormalities in the ancestors of these children. There is perhaps nothing that is more hereditary than sexual perversions. You will find in an exceedingly large number of the cases collected in Europe that insanity is a prevailing condition in the immediate antecedents of the children. You will find various forms of cerebral perversions in the way of epilepsy, hysteria, melancholia, etc. One very remarkable point or characteristic is the especial fondness for music on the part of the male members of such families.

In the matter of therapeutics, I can well see how a boy that has been taught to masturbate may be benefited by such local means as described by Dr. Simpson, and perhaps this, in connection with a little moral persuasion, constitutes our chief means of treatment; but in a congenital masturbator, inheriting from one or both sides that condition of the nervous system which in numbers of instances leads to congenital self-abuse, the difficulties of any local treatment may be easily recognized. This class of cases should be treated exclusively by the same line of practice as is employed in pronounced forms of insanity. It is a form of insanity inherited by the child. All those means calculated to increase the physical development of the child and to counteract his unfortunate hereditaments should be the chief concern of the doctor. I do not believe that these cases of congenital onanism can by any possibility be cured by local counter-irritation or by drugs, but the treatment should be directed to the physical and moral nature of the child. It is not simply a matter of daily involuntary discharge of urine to be corrected, but it is to save the child from the sexual perversions and other horrors that follow in the track of the mental obliquity that first manifests itself in congenital masturbation. Certainly this is a matter that should be looked into with the greatest care, not simply because of the primary trouble, the daily involuntary discharge of urine, but because of the graver dangers that threaten the child when he comes to man's estate.

Dr. J. B. Marvin: Dr. Palmer has spoken of only one aspect of the subject, and I agree fully with him on that point, but I differ very radically with the essayist in narrowing down these cases of enuresis, diurna, nocturna, and occasional, to masturbation. A very large proportion of these cases are not due to masturbation. I see a great many cases of this kind, and relief usually follows the ordinary treatment, watching the diet, and especially the amount of water they use, etc. I

have never resorted to the methods laid down by the essayist for the treatment of this condition in children. There is no question that the sphincter is very slightly developed in the child, which may explain why they can not retain the urine. The sphincter becomes more developed after a certain age, and the child can then hold his water. I do not think it is proper to class these cases under the head of masturbators.

Dr. Larrabee: I was very much interested in the most excellent paper read by Dr. Simpson. Ten years ago I became interested in this subject. I notice that the paper simply included males, therefore I do not suppose the discussion pertaining to female children, who are about equally affected by the habit of masturbation, in my experience, is in order, but I would like to mention three cases I have recently seen. The children are all female, aged five, six, and ten years, and all masturbators. In two of the cases I found the trouble to have been excited by a condition not yet mentioned; that is, the presence of ascarides in the rectum. I believe this is possibly a factor in a great number of cases. These two patients were relieved by getting rid of the worms. The irritation produced in the rectum or the possible presence of ascarides in the vagina probably directed the attention of the children early to these parts, and the slyness and manner in which the child of six years resorted to the act of masturbation, if it had not been serious, was somewhat amusing. She would steal away by herself, get on a chair, and immediately commence a system of wriggling. Her face would turn red, the orgasm would be reached, and she would drop back exhausted. This was repeated from twenty to thirty times a day.

While I am inclined to believe that many cases of enuresis may be due to the cause spoken of by Dr. Simpson, I agree fully with Dr. Marvin that the vast proportion is due to other causes. I think the nervous element spoken of by Dr. Palmer may have a great deal to do with these cases, they being children of nervous parentage are liable to develop not only this condition, but all the train of nervous symptoms. Such children are prone to chorea.

I have never had to resort to the measure of blistering or keeping the parts sore in the treatment of enuresis. The paper I suppose does not include the ordinary bed-wetting. Prof. Watson read a paper before the American Medical Association, three or four years ago, including a very large number of children treated for enuresis, incontinence of urine both day and night. The success of his treatment was so remarkable that I have adopted it. Of course we all use sedatives to the blad-

der, we use belladonna, etc., but I do not think we use these remedies exactly as he does. Watson makes a solution (and we all know the tolerance of children to that drug) of one grain of sulphate of atropia in one ounce of distilled water, giving as many drops as the child is years old; probably the average dose would be five to eight drops. This is the point I want to emphasize and impress upon those who use belladonna, viz., that in order to obtain the desired result it is necessary to produce the physiological and even the toxical effects of the drug.

I remember the last case I treated was a child sent to me from Paducah, Ky. This child had belladonna delirium following the administration of this drug, and as soon as this was produced the bed-wetting, which had lasted for four years, ceased, and never returned. Watson says, very properly, that unless the drug is pushed to that extent a cure will not follow.

Of course in the treatment of enuresis there are other things which should be taken into consideration. Many cases are due to a condition of the urine, and that should be attended to. In some cases I have resorted to the use of benzoic acid, in others it has been necessary to give turpentine, cantharides, etc. Where a tonic treatment is indicated I have found nothing better than syr. iodide of iron. I simply want to record these remedies as having been successful in my practice.

Dr. Palmer: I believe Prof. Harrison has shown that it is not the sphincter interna, but the prostate that controls the urine. It has been shown that the prostate is not a gland, but a muscle with gland follicles embedded in it. The sphincter is so weak as to be practically of very little use even in adult life, while the prostate surrounds the neck of the bladder and controls it by contraction. This explains why a boy is eventually able to retain his urine by the development of his prostate which comes in later years.

Dr. F. C. Simpson: In the paper I simply called attention to what seemed to be incurable cases, patients that have been treated with every possible care and with every drug that is known to the profession to be beneficial in conditions of this kind, still they continue to wet the clothing. There is no evidence of it at night; they go to bed and sleep well, and do not wet the bed during the night. I can not attribute it to any thing except the tendency to masturbation. As a proof that the trouble is due to masturbation, I will state that while the parts are kept blistered the urine is retained, but as soon as healing takes place the clothing is again wet.

I do not mean to say that all children who suffer from this condition are masturbators; I stated that in these intractable cases I could discover no other cause.

Dr. W. Cheatham read a paper on *Leptothrix Mycosis of the Tonsil, Larynx, and Base of the Tongue*. [See page 361.]

DISCUSSION.

Dr. J. M. Ray: These cases of so-called mycosis are comparatively common. When I first commenced treating throat diseases this form was called "chronic follicular tonsillitis." The fungoid mass springs from the crypts of the tonsils, and therefore may often be taken for accumulations of secretions in the crypts; only the microscope will tell positively. In the last few years there have been a great many articles written on the subject, and it is now recognized by all throat specialists as due to some fungoid formation. Several cases that I have seen have been of a very aggravated form, in which not only was the tonsil involved, but also the pharynx and the base of the tongue. You can take a curette and scrape out these growths, but they will return, no matter what form of medication is applied afterward. The only treatment I find to result in permanent cure is to destroy the follicle from which they spring. This can be very readily done by spraying with cocaine and applying the galvano-cautery.

Dr. S. G. Dabney: I have lately seen several cases of the character under discussion, and would like to make a few points in regard to the symptoms, diagnosis, and treatment. I do not agree with Dr. Ray that follicular tonsillitis is the same as *leptothrix mycosis*. Differentiation between the two diseases is easy. In follicular tonsillitis the exudations are more yellowish in color and very much easier gotten out of the tonsil. In mycosis the growths are shaped like a spear, and are very hard to get out. My experience is that in mycosis the patient complains chiefly of a foreign body in the throat. I have found more of the growths on the base of the tongue than on the tonsil proper.

In regard to treatment: Of course the best thing to do is to get out this little mass. Nothing I, think, is equal to the curette or forceps. I have used electro-cautery, but in the last two cases I have changed to chromic acid with much better result. Attention to general health is often needed. Usually the digestive system is out of order; sometimes we find a rheumatic tendency. The paper quoted by Dr. Cheatham was read by Dr. Knight at the last meeting of the American

Laryngological Association. In the discussion which followed the consensus of opinion was that the disease was best treated by removal of the formation, and the application of the electro-cautery, with appropriate means for the general health.

Dr. Cheatham: There is no doubt in my mind that there is a follicular tonsillitis, as well as a tonsillitis depending upon mycosis leptothrix; and that there are more cases of the former than of the latter. I have examined seven cases lately with the microscope and found leptothrix threads in but two; in one case in which every follicle was filled with white masses I could not find a thread; some of these specimens, that of the the latter case among them, I had a well-known microscopist examine with the same result as my own. So, instead of a majority of such cases depending upon mycosis leptothrix, they are cases of so-called follicular tonsillitis.

Dr. H. A. Cottell: There seems to be some confusion of terms in the names applied to this affection. The term "leptothrix" is commonly applied to the schizomycetes or microbes, while the term "mycosis" refers to mucorini or the moulds. These belong to two distinct natural orders in microscopic cryptogamic botany. Some of the moulds appear in chains, and might, perhaps, be called leptothrix, but the application of the term to moulds proper is unusual if not incorrect.

The micro-organism of the disease described by Dr. Cheatham would seem to be similar in character to the *oidium-albicans*, which is the parasite of aphthous sore mouth.

J. E. HAYS, M. D., *Secretary.*

THE LOUISVILLE CLINICAL SOCIETY.*

Stated Meeting, April 4, 1893, Dr. I. N. Bloom, President, in the chair.

Dr. W. O. Roberts: (Tumor of the Breast.) I have had a run on malignant diseases of the breast in the last week, having had four cases, the last of which was operated upon to-day, all of them being patients sixty years of age. The tumor removed to-day was first noticed three years ago. Some two months before the lump was detected the lady had a fall, striking her breast against a chair, which gave her very little pain, still she seems to attribute the trouble to that blow. She tells me that the breast a year ago was very much larger

*Stenographically reported by C. C. Mapes.

than at the time of its removal to-day. It has given her a great deal of pain. No enlargement of the glands in the axilla could be detected prior to operation, but after the space was opened I found two glands that were about as large as a hazelnut. It has all the characteristics of schirrus—retraction of the nipple, and hard, indurated feel of the tumor—and it will be seen upon examination that the muscle seems to have become involved in the growth, the muscle drawn up as it were into the tumor. The greater part of the pectoralis major muscle was removed, and the axilla thoroughly cleaned out, not only the glands, but all fatty tissue, leaving the vessels and nerves exposed.

DISCUSSION.

Dr. J. M. Mathews: Do you ever remove the glands in the axilla, unless you can feel that they are indurated or enlarged?

Dr. Roberts: I take them out always. Unless this is done I think the operation does not hold out much to the patient, and recurrence is apt to take place quickly.

Dr. Mathews: The reason I ask the question is, that I have seen quite a number of operations for excision of the breast where the operators paid no attention to the glands of the axilla unless an enlargement could be felt.

Dr. J. M. Krim: (Twin Pregnancy; Death—One Fetus at Four Months, the Other Born Alive.) Twelve days ago I was called to attend Mrs. T. in her third confinement. The history of the case is, that she gave birth to twins the first time, second time single, and this time, when I was called, she said she had "about three weeks to go." I made an examination and found her in the first stage of labor; I remained seven hours, I think, and the child was born matured, but rather small, weighing about $6\frac{3}{4}$ pounds. A few days afterward I was telephoned to return at once as the patient was suffering with terrific pain. I went back, made an examination, and found protruding through the os something soft, and, after making slight traction, it ruptured, and a very fetid substance came away shortly afterward, which proved to be a macerated fetus at about the fourth month. The uterus was thoroughly douched and cleansed out, and the patient made an uninterrupted recovery.

The reason I report the case is to get the opinion of the Society as to whether this was a twin pregnancy or a subsequent pregnant condition. The child delivered on my first visit is still alive, apparently

not fully grown, was about the eighth month. The fluid which came away on my second visit seemed to be perfectly clear, but had a very fetid odor.

DISCUSSION.

Dr. I. N. Bloom: How long had the patient been married, and what were the intervals between the various pregnancies?

Dr. Krim: Married eight years. First delivery fifteen months after marriage; second, four years after the first, this being the third, which is about three years after the second.

Dr. T. P. Satterwhite: I do not think there can be any doubt but both impregnations occurred during one coition. It is proven, according to Gaston, that there are never true twins unless they are enveloped in the same sac.

Dr. Roberts: Do you know if there was at any time during pregnancy any uterine hemorrhage?

Dr. Krim: This patient belongs to the working class, and said that at one time while sweeping she felt a peculiar pain which lasted probably two or three hours, after that she felt nothing more of it. She said of course that she felt some pain occasionally, but attributed it to the condition she was in, as she had noticed the same pains in previous pregnancies.

I am of the opinion it was a twin pregnancy, two placentas; but why one ceased to grow at four months and the other go on to nearly full term I am unable to say.

Dr. Roberts: (Epicystotomy for Removal of Catheter from the Bladder.) I performed an epicystotomy week before last on a man sixty-five years of age. The history was that he had some trouble in passing urine and had to occasionally use the catheter to empty his bladder. He was a hard-drinking man, and three weeks before I saw him he had occasion to use the catheter, which he said had not been necessary for some months before, and after introducing it into the bladder it broke off. He said it was one of those red-rubber instruments, and he was in hopes that he would be able to pass the piece that was left in the bladder, but this did not occur. Violent cystitis developed, and his physician consulted me on the subject; I told him the only thing to do was to perform a cystotomy and remove the portion of catheter. The patient came here, and I intended keeping him in the infirmary for a few days to prepare him for the operation, but he said he would remain at the hotel until the preliminary treatment had been carried out. In

the afternoon (Tuesday) I went to the hotel and found that the patient had gone to the infirmary. When his son had come to my office to consult me about the operation the old gentleman had gotten on a big spree, and the boy took him immediately to the infirmary. Tuesday evening he was very drunk; Wednesday he sobered up, and we managed to keep him in the house until the next day, when I operated. I removed from his bladder two pieces of catheter, one about two inches the other one inch in length, and each piece was heavily coated with salts from the urine. I suppose the coating was at least one sixteenth of an inch in thickness. They were not broken in the attempt to remove the fragments during operation, because they were entirely covered with this coating, showing that there were originally two pieces in the bladder. The technique of the operation was about this: A rubber bag was introduced into the rectum and distended with air, then the bladder was filled with water—I say filled, eight ounces being put into it—then an incision made and the bladder opened. The incision was made a little too low, I got a little in front of the point where I wanted to open the bladder, and went into the upper wall of the prostate. I recognized this fact simply by the considerable amount of hemorrhage at the time. I carried my incision on into the bladder, removing the two pieces of catheter, and the man recovered without an untoward symptom, and without the slightest elevation of temperature. He was up on the sixth day sitting in a chair. He now spends most of his time sitting at the window in his room at the infirmary.

DISCUSSION.

Dr. I. N. Bloom: How did you treat the bladder wound afterward?

Dr. Roberts: After removing the catheter I washed the bladder out very thoroughly with hot boric-acid solution, then introduced a strip of iodoform gauze, draining the bladder in that way for twenty-four hours, then took the gauze out. Did not use any sutures in the bladder at all, or in fact anywhere.

Dr. Bloom: I was connected with a case of epicystotomy a few days ago in the role of consultant, another gentleman doing the operation. Dr. Schachner asked me to see a case in consultation, the patient giving unmistakable clinical history of stone. He had not up to that time sounded for stone, and I advised that this be done, feeling sure that we would find one. This proved to be the case, and I was asked to be present at the operation for its removal. He did an epicystotomy

very neatly and dextrously; there was no hemorrhage. He used the colpeurynter, distending the rectum with about eight ounces of water; there was no trouble with the peritoneum; the stone removed was phosphatic, oval in shape, and weighed one ounce, two grains. The after-treatment differed from the method mentioned by Dr. Roberts. He sutured the bladder; by the way I do not think it is ever possible to select the muscular coat and be absolutely certain that you have not included some portions of the mucous coat. In closing the external wound he left a glass drainage-tube in the lower angle for a day, and leaving a permanent catheter inserted for forty-eight hours. The patient did uninterruptedly well. The only difference in the technique of the operation between the two was in the after-treatment. I ask for information, and would like to know why Dr. Roberts used the method he spoke of, the open treatment, without stitching the bladder.

Dr. Roberts: I preferred it because the man had cystitis; the principal object in the open treatment was to get rid of the cystitis.

Dr. Roberts: (Stricture of the Esophagus.) A man, twenty-eight years of age, who had typhoid fever in December was given permission by his physician to eat solid food on the third day of February last. He had a chicken cooked, but when he made the attempt to eat it he found that he was unable to swallow. He was brought to me the other day, and I believe he has a complete stricture of the esophagus. I did not use the esophageal tube to see whether or not it could be passed, but his physician told me that a little over four weeks ago he passed a tube into the stomach and the patient then attempted to pass it himself, but it bled considerably, so he desisted. I examined him as carefully as I could, and could detect no evidence of any tumor or any trouble with the heart or aorta producing pressure upon the esophagus interfering with deglutition in this way, and had him taken to the infirmary. Shortly after going there he began to improve, was able to take milk without any trouble, and I took it that the stricture was due to some local or reflex trouble that would pass away, but for the last three days he has been unable to swallow any thing at all, and is running down. I would like to know if any Fellow has ever met with a similar case.

DISCUSSION.

Dr. P. Guntermann: I saw a case reported in the New York *Medicinishe Monatschrift*, where a very similar state of affairs existed after convalescence from typhoid fever, the patient suddenly was unable to

swallow. A tumor was detected, however, causing complete closure of the esophagus, and in a very little while the man died. A *post-mortem* was held revealing a little typhoid ulcer in the esophagus, which let fluid enter in between it and the trachea, closing up the esophagus and trachea. There may have been something of this kind in the case reported by Dr. Roberts.

Dr. P. Guntermann read an essay on Chloroform Anesthesia and its Administration. [See page 364.]

DISCUSSION.

Dr. L. S. McMurtry: In the consideration of this important subject one question deserves special attention, viz., who should administer anesthetics. Generally speaking every physician ought to be qualified to administer anesthetics, and in obstetrical practice anesthetics are given with impunity and safety without any special skill. When we consider the daily frequency with which anesthetics are used in skilled and unskilled hands, and under all varieties of conditions and complications, it is remarkable that so few accidents occur. But there is something more in administering anesthetics than procuring respite from pain without the immediate death of the patient. Anesthetics can do serious damage in surgical cases without producing sudden death. Prolonged and profound saturation with anesthetics is often the cause of death after surgical operations, which are classified as deaths from shock. I do not believe we can too strongly emphasize the responsibility of the anesthetist in surgical work. That is a position of the highest responsibility, and requires judgment, care, and skill, and since the operator assumes all responsibility it is a position of high trust. The duty of an anesthetist should be intrusted only to those who have learned how to administer these agents, and who realize the responsibility. In this, as in other features of surgical work, much of success depends upon attention to details. Fright is of itself an element of danger in anesthesia. The anesthetist should be introduced to the patient, and establish confidence and give assurance. The operation, however trivial, should not be begun until anesthesia is produced; by this I mean insensibility to pain. And then a certain degree of anesthesia should be maintained, using the smallest quantity of the drug possible to attain this condition.

My friend, Dr. Kynett, of Philadelphia, who has had an exceptionally rich experience with anesthetics, has called attention to a valuable

sign of the danger-line in anesthesia. When the addition of fresh ether to the cone fails to produce an up-and-down movement of the wind-pipe the ether should be withdrawn; when that movement occurs the condition is a safe one.

Dr. J. W. Guest (visiting): I have listened with a great deal of interest to the paper read, and heartily indorse it in substance. I have found from my personal experience, however, four points in which I would slightly differ from the essayist:

1. I believe that the stomach should be entirely empty, if possible, at the time the anesthetic is administered. Of course if there be nothing practically in the stomach, that much less will the vomiting be.

2. In regard to watching the respiration: In giving chloroform about four hundred times I have had eight accidents, or seven accidents and one death; and I have noticed that the circulation and not the respiration was the first to disappear.

3. Concerning the cone: I formerly used the towel and paper cone, but in the last one hundred cases I have employed the Esmarch cone and bottle, which I think is decidedly the best and safest cone that I have ever seen.

4. Those patients who fear chloroform most, usually take it best.

Dr. Mathews: I suppose I am recognized as a chloroformist, because I believe honestly in the administration of chloroform in preference to ether. I have never had an accident or a failure in administering it; I do not know how often I have given it, but would say between two and three thousand times since I began the practice of medicine. I have administered it four times to-day.

One of the greatest points of interest to be discussed in this matter is, which is the safer anesthetic of the two. And this is the reason I suggested that we be allowed to mention these points. I believe that if you will take your patients indiscriminately and treat them as physicians usually treat them, that is, without paying any attention to the points brought out by Dr. Guntermann, it can be demonstrated that chloroform is the safer anesthetic. Dr. Guntermann very properly says that the heart should be examined; he should also have added that the urine should be examined, but who does it?

If you will permit me to say in this connection, it has not been many months since I saw, in consultation with one of our most eminent physicians, a case in which it was decided to do an operation, and this physician said, for safety we will give him ether. It was understood that

he would make an examination of the urine prior to administration of the anesthetic, but he failed to do so. Reaching the place where the patient was, and having no ether, we decided to give chloroform. An analysis of the urine was made afterward, and it was found to contain a very large percentage of albumen. The patient died in less than six months with albuminuria. We gave him chloroform; could we have given him ether safely?

I believe, therefore, if you will take the patients as they come, hospital, dispensary, and private, recognizing how common diseases of the kidney, etc., are, that we have the safest anesthetic in chloroform.

Under the first proposition of the essayist, as to who can take chloroform, there is a medico-legal point involved. The law holds the physician responsible for deaths from anesthesia, if he is derelict in his duty, and this is done upon the idea that the physician should make an examination of the patient before he gives the anesthetic. In other words, it is presumed we know why patients die from anesthesia. I doubt if we do. Such able physicians as McBurney and McLane have stated that they believed edema of the lungs caused the death of Col. Shepherd. I have heard it hinted, at least by physicians here, and there is a doubt expressed even in their own report, whether that was the case or not. The question, without a *post-mortem*, can not be settled whether, for instance, this man had any serious kidney trouble, and that that was the cause of his death. While it is stated that they made an examination of the urine formerly, from my reading of the case I infer they had not done so recently.

As to who can take chloroform, I must confess that I have given it in heart trouble, where there was organic disease; I have given it where there was organic disease of the kidney; I have given it to exceedingly nervous women—and I want to say in this connection that I perfectly agree with Dr. Guest that nervous, hysterical women take chloroform better than anybody else. In other words, those who dread the anesthetic, those of highly sensitive natures go quickly under its influence, and have less trouble than any other class of people. I do not believe we can tell by looking at a patient how he is going to take chloroform. It has been my personal observation that fat large men take a less amount of chloroform than small or delicate men. A member of this Society will remember a case where a man weighing fully two hundred pounds was thoroughly anesthetized by one whiff of chloroform, and remained so for twenty or thirty minutes.

As to the signs evidenced that a person is under the effect of the anesthetic, Billroth, in his clinic, proposes the method of having the patient count from one to as many as he can, and when he ceases counting he says he is ready for operation. I have tested this, and believe it a good plan. I have seen many cases where the pupil failed to be a good guide. My habit has been (and I believe it a good one) to lift the arm and ask the patient to hold it in that position; as long as he does so, or as long as there is an effort made in that direction he is not ready; when the arm drops he is ready for the operation. I believe I have never known this to fail.

In regard to stertorous breathing, Dr. Guntermann has very properly said that when this occurs chloroform should be immediately stopped. He also says any effort at vomiting, an attack of nausea should be an indication for ceasing the administration of chloroform—if this were done in all cases you would be unable to operate many times.

As to the method of giving chloroform, I believe that it is the consensus of opinion that chloroform should be given rapidly and yet carefully. I dislike very much to have an assistant who seems to be afraid of giving too much chloroform, and gives too little. I am satisfied that deaths do occur in the manner spoken of by Dr. McMurtry under partial anesthesia. So thoroughly am I convinced of this that I will not touch the rectum to do a surgical operation until the patient is profoundly under the influence of the anesthetic, not even to stretch the sphincter muscle. There are many points that might be brought out in this discussion. What we know about chloroform comes more from one's experience and observation. Those that have been in the habit of giving chloroform without accident will prefer it; the same can be said of ether.

Dr. George W. Griffiths: I am in favor of chloroform to the entire exclusion of ether. I have seen chloroform administered at Shiloh, Chickamauga, Stone River, Perryville, in hundreds of cases, all sorts of men with all sorts of injuries, and in all that time, in fact in all my experience, extending over a period of more than twenty-five years, I have never seen but one death, and that occurred at the first battle at Green River, in 1861. I do not believe in the use of a cone; I think the chloroform should be used on a napkin; and given in this way it lessens the danger, as it is by this method that it is better mixed with the atmospheric air.

Dr. Satterwhite: I prefer chloroform to ether. One of the most objectionable features of ether is the sensation of suffocation. I believe

in the administration of chloroform, but think a man ought to administer it very cautiously. I agree with what Dr. Griffiths has said with regard to the admixture of atmospheric air with the chloroform. I differ with Dr. Guntermann in this particular: in the stage of excitement which we often have in the administration of chloroform I push the chloroform more vigorously than at any other time. I would like to say with regard to what Dr. McMurtry alluded to, and which I supposed every member of the Society knew, the universal custom is that the anesthetist shall make a charge for his services. I would not think of asking a man to administer an anesthetic without expecting him to make a charge. In nine tenths of the surgical operations the anesthetist has the most responsible position.

Dr. Bloom: It is largely a question of locality as to the preference for ether or chloroform. In Boston, and with those people who have gone there to complete their medical education, ether is used almost exclusively. In the South and West for some years chloroform has been employed universally. I think any one who reads the journals will see the tendency toward returning to ether—an increase of ether advocates. In New York it is about evenly divided, and apparently remains *in statu quo*. It is claimed (I received my education in Boston) that the mortality in a given number of cases, say in possibly 100,000 cases, was less from ether than from chloroform. I know that this is the principal reason why ether is advocated by those who teach the use of anesthetics in surgery in Harvard College. Now I also know that there is no strong advocate of chloroform who does not maintain that the mortality is less from chloroform. I do not think any of us here are competent to judge. I think there is only one way of demonstrating this, and that is to take the first 100,000 cases, or even a greater number of cases, and following up the mortality—and even then it is not satisfactory. A man may have a death from imperfect knowledge of the method of administering, or, as has been suggested very properly by Dr. McMurtry, by incomplete anesthesia. I do not think any discussion among a few men will convince either side as to which is the better anesthetic to use, and I believe it is like the discussion of a political question, “when it is finished you are unchanged in your opinion.”

Dr. Guntermann: I simply wish to remark that in my paper thus far nothing whatever was said with reference to ether, although the discussion seems to have branched off in that direction.

T. C. EVANS, M. D., *Secretary*.

THE AMERICAN PRACTITIONER AND NEWS.

"NEC TENUI PENNÂ."

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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This journal is devoted solely to the advancement of medical science and the promotion of the interests of the whole profession. Essays, reports of cases, and correspondence upon subjects of professional interest are solicited. The editors are not responsible for the views of contributors.

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JOHN P. MORTON & COMPANY, Louisville, Ky.

THE KENTUCKY STATE MEDICAL SOCIETY.

The May meeting, last week, at the State Capital was a brilliant success in every particular. We have seen no member returned from the meeting who was not lavish in his plaudits of what there took place. Our next issue will contain the first installment of the report of the proceedings, and that and subsequent issues will lay before our readers in full text all but a very few of the papers read.

The election of Dr. J. Q. A. Stewart to the presidency is an honor fitly placed.

THE NEW LAW REGULATING THE PRACTICE OF MEDICINE IN KENTUCKY.

The war against quackery, so vigilantly pushed by our State Board of Health for the past two or three years, is slowly showing salutary results. It has caused not a few notorious quacks to pack up and go out in search of new pastures, and will, at no distant day, make Kentucky forbidden soil to those peripatetic rascals who have so long played the role of medical mountebanks on the "Dark and Bloody Ground." The old humbugs who have time, public credulity, and the certificates of ministers to back their pretensions to the art of healing

seem, at least in Louisville, too strongly entrenched for official dislodgment; but when these die off the ranks can never again be filled except by deserters from the ranks of regular medicine. Unfortunately we have not a few charlatans of this description, who daily advertise in the papers and practice upon patients secured by such means.

To date the problem of abating this nuisance has proved too much for our medico-legal magnates; but it begins to look as if its solution were no longer doubtful. On the tenth of April our General Assembly passed the "New Law," which we append without curtailment. We have not asked legal advice in the matter; but are quite sure that Section 5, which is italicized, may be used as a weapon for the routing of such of the advertising pseudo-professional gentry as at present hold the field by virtue of diplomas, which, though given them in good faith by the schools from which they graduated, have been perverted to shameful uses. It is to be hoped that every reputable doctor in the State will give the new law a thoughtful reading, and will make haste to obtain the required certificate, so that the Secretary of the Board may not have any difficulty in determining who is not entitled to practice under its provisions, and may find no regular practitioner in his way when he shall open the fall campaign against the quacks with and without diplomas.

Here is the new law:

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

Section 1. It shall be the duty of the county clerk of each county to purchase a book of suitable size, to be known as the Medical Register of the county, and to set apart one full page for the registration of each physician, and when any physician shall die or remove from the county he shall make a note of the same at the bottom of the page; and said clerk shall, on the first day of January in each year, transmit to the office of the State Board of Health a duly certified list of the physicians of said county registered under this law, together with such other information as is hereinafter required, and perform such other duties as are required by this law; and such clerk shall receive the sum of fifty cents from each physician so registered, which shall be his full compensation for all the duties required under this law.

Section 2. It shall be unlawful for any person to practice medicine, in any of its branches, within the limits of this State, who has not exhibited and registered in the county clerk's office of the county in which he resides his authority for so practicing medicine as herein prescribed, together with his age, address, place of birth, and the school or system of medicine to which he proposes to belong; and the person so registering shall subscribe and verify by oath, before such clerk, an affidavit containing such facts,

which, if willfully false, shall subject the affiant to conviction and punishment for perjury.

Section 3. Authority to practice medicine under this law shall be a certificate from the State Board of Health, and said board shall, upon application, issue a certificate to any reputable physician who is practicing, or who desires to begin the practice of medicine in this State, who possesses any of the following qualifications: First. A diploma from a reputable medical college legally chartered under the laws of this State. Second. A diploma from a reputable and legally chartered medical college of some other State or country, indorsed as such by the State Board of Health. Third. Satisfactory evidence from the person claiming the same that such person was reputably and honorably engaged in the practice of medicine in this State prior to February 23, 1864. Applicants may present their credentials by mail or proxy, and the board shall issue its certificates to such applicants as are entitled thereto as though the applicant was present. All certificates shall be signed by the president and secretary, and attested by the seal of the board, and not more than two dollars shall be charged for any certificate.

Section 4. Nothing in this law shall be construed as to authorize any itinerant doctor to register or to practice medicine in any county in this State.

Section 5. *The State Board of Health may refuse to issue the certificate provided for in Section 3 of this article to any individual guilty of grossly unprofessional conduct of a character likely to deceive or defraud the public, and it may, after due notice and hearing, revoke such certificates for like cause.* In all cases of refusal or revocation the applicant may appeal to the Governor, who may affirm or overrule the decision of the board, and this decision shall be final.

Section 6. Nothing in this law shall be so construed as to discriminate against any peculiar school or system of medicine, or to prohibit women from practicing midwifery, or to prohibit gratuitous services in cases of emergency; nor shall this law apply to commissioned surgeons of the United States Army, Navy, or Marine Hospital Service, or to a legally qualified physician of another State, called to see a particular case or family, but who does not open an office or appoint any place in this State where he or she may meet patients or receive calls.

Section 7. It shall be the duty of the State and local Boards of Health to bring to the attention of the courts any violations of the provisions of this law within their respective jurisdictions.

Section 8. Any person living in this State, or any person coming into this State, who shall practice medicine, or attempt to practice medicine in any of its branches, or who shall perform, or attempt to perform, any surgical operation for or upon any person within the limits of this State, for reward or compensation, in violation of the provisions of this law, shall, upon conviction thereof, be fined fifty dollars, and upon each and every subsequent conviction shall be fined one hundred dollars and imprisoned

thirty days, or either or both, in the discretion of the jury; and in no case, where any provision of this law has been violated, shall the person so violating be entitled to receive compensation for services rendered. To open an office for such purpose, or to announce to the public in any other way a readiness to practice medicine in any county, shall be to engage in the practice of medicine within the meaning of this law.

Approved April 10, 1893.

Notes and Queries.

To the Editors of the American Practitioner and News :

CARDIAC STIMULATION IN CROUPOUS PNEUMONIA.—I was much interested in the paper which recently appeared in your valuable journal on the above subject, by Dr. John A. Larrabee, especially that part of it which relates to the use of digitalis. While I do not wish to dissent from the conclusion of the author, based, as he claims, upon clinical experience, I think a very important principle relating to the subject has been omitted, both by the paper and the discussion following. It is assumed that the great danger of cardiac failure in croupous pneumonia arises from mechanical obstruction, and the question is asked whether or not it is wise to goad the heart, already laboring against great resistance, to greater exertions, or, in other words, to increase the resistance by the use of such an agent as digitalis.

That there is great danger to the right heart from obstruction to the pulmonary circulation, I will willingly admit; but is this the only source of heart failure? It occurs to me that failure of this organ may result from mal-nutrition as well as overwork, or because of deficient nourishment the heart is less able to endure the strain placed upon it.

In all acute infectious diseases which induce rapid action of the heart and high temperature there is a strong tendency to asthenia.

There are two efficient causes which conduce to such a result; first, the rapid action of the heart is inconsistent with its own nourishment, not allowing time for a sufficient quantity of blood to flow through the mouths of the coronary arteries; second, a blood supply deficient in the elements of nutrition or laden with noxious material which causes degeneration of the the heart muscle. In croupous pneumonia both these disadvantages are encountered. The blood in this disease is peculiarly liable to become unfit for perfect nutrition because of the obstruction to the pulmonary circulation. Now, may we not subserve the nutrition of the heart and thereby save it from degeneration due to deficient nourishment, by slowing its action with digitalis? And is it not possible that this drug by contracting the arterioles and increasing the blood pressure contributes to the pulmo-

nary circulation, thus rendering the blood better suited to sustain the heart as well as other tissues? Of course it would be unwise to administer such a remedy just as the right heart is about to succumb from overdistension. This would probably induce immediate paralysis. But might not this calamity often be averted by the timely use of such drugs as will tend to maintain the integrity of the heart-tissue; or, in other words, to preserve the heart from degenerating influences? Would not digitalis, if employed early and its effects properly observed and controlled, accomplish something in this direction.

C. T. BURNETT, M. D.

OAK GROVE, TENN.

THE SOUTHERN MEDICAL COLLEGE ASSOCIATION met in the hall of the Academy of Medicine, Nashville, Tenn., April 20, 1893, at 10 A. M. The following colleges were represented: Medical Department University of Louisville, by Dr. J. M. Bodine; Louisville Medical College, by Dr. C. W. Kelly; Kentucky School of Medicine, by Dr. J. B. Marvin; Medical Department University of Tennessee, by Dr. W. D. Haggard; Medical Department University of Nashville and Vanderbilt, by Dr. G. C. Savage; Southern Medical College, Atlanta, by Dr. Thos. S. Powell; Chattanooga Medical College, by Dr. E. A. Cobleigh; Knoxville Medical College, by Dr. J. C. Cawood; Memphis Hospital College, by Dr. F. L. Sim; Medical Department Tulane University, by Dr. A. B. Miles; Medical College of Alabama, Mobile, by Dr. Ketchum; Medical Department of the University of the South, by Dr. J. S. Cain. It was decided that a certificate signed by the one in charge of any of the required Laboratories should be evidence of attendance upon same. The time to be devoted by each student in each of the laboratories shall be determined by each college. Examinations for degrees may be either written or oral or both. Dr. Marvin moved and Dr. Ketcham seconded that this Association disapproves of the beneficiary system or commutation of published rates. Carried unanimously. By vote it was acceded that all colleges belonging to this Association may regulate their own fees. The officers (President and Secretary) were directed to request that State legislatures repeal all laws compelling their Medical Colleges to receive beneficiaries. It was recommended that all colleges belonging the Association shall charge the same fee for Professors' tickets for each of the three courses. It was also agreed that the matriculation fee should be paid each year. The question of grading the courses of study was deferred until the annual meeting in New Orleans next November. It was agreed that one year's study shall be credited to all matriculates who are graduates in Pharmacy or Dentistry. The question of giving credit for one year's study to graduates in Veterinary Surgery was referred to the President, Vice-President, and Secretary for final action, the same to be reported to all the colleges of the Association. Dr. Haggard moved (there were numerous seconds) that the colleges of this Association will not recognize the tickets of colleges issued after 1893-4, which required only two courses

of lectures for graduation. The Secretary was allowed to make reasonable expenditure for stenographic and type-writing work in carrying on the business of the Association. The President, Vice-President, and Secretary were directed to frame the certificates required of students before matriculating, and furnish a copy of same to each college, the same to be copied in all the catalogues. By motion of Dr. Cobleigh, the President, Vice-President, and Secretary were constituted an Executive Committee with power, when the Association is not in session, to construe our regulations regarding all questions of scholastic bearing which may be submitted to them by members of this Association, subject to appeal to the Association at its next meeting, or reversal on protest by mail from a majority of the affiliating schools. Notice of these rulings shall be sent all schools immediately. The Secretary was instructed to correspond with the Secretaries of the several State Medical Societies of the South, asking that each society pass a resolution to the effect that they will recognize no Medical College whose requirements are less than those of the Southern Medical College Association. The Secretary was directed to report the enactments of this meeting to all the colleges of the Association, the publication of any part of which, except the two certificates, is left to each college. The following are the two certificates which the committee were ordered to frame, and which shall be published in all catalogues :

(1)189

Secretary (or Dean) of.....(City).....(State).....

Dear Sir :

Mr.....of.....is a gentleman of good moral character. I recommend that he be allowed to enter upon his medical studies in your college. He has been my pupil.....months.

Yours,

(Sign here).....

(2)189

Secretary (or Dean) of.....(City).....(State).....

Dear Sir :

I have examined Mr.....of.....and find his scholastic attainments equal to those required for a second-grade teacher's certificate, in our public schools.

Yours,

.....Supt. Pub. Instruction.

The Association adjourned to meet in annual session in New Orleans, La. next November.

G. C. SAVAGE, *Secretary.*

AMERICAN ACADEMY OF MEDICINE. PRELIMINARY PROGRAMME OF THE MEETING FOR 1893 AT MILWAUKEE. Saturday morning, June 3d, at 10 o'clock, Executive business ; Report of Committee: (1) On Eligible Fellows. (2) On the Requirements for Preliminary Education in the various Medical Colleges in the United States and Canada. (3) On the comparative value of Academical Degrees. Papers: (1) The Attitude of our Medical School in Relation to Preliminary Studies. R. Lowry Sibbet, Carlisle,

Pa. (2) What Mental Faculties should be specially trained for the study of Medicine? James W. Moore, Lafayette College. (3) The Classics and Common Schools. J. Berrien Lindsley, Nashville, Tenn. Saturday afternoon at 2.30 o'clock, President's Address. Papers: (1) What should be required in an Entrance Examination to a Medical School? James W. Holland, Jefferson Medical School. (2) Should there be Elective Studies in a Medical course? P. S. Connor, Medical Department, Dartmouth College. (3) On the Endowment of Medical Schools. George M. Gould, Philadelphia. Re-union session, Saturday evening. Monday morning, June 5th, at 10 o'clock, Executive business; Report of the Committee on the Laws regulating the Practice of Medicine. Papers: (1) The Duty of the State to Medicine. Benjamine Lee, Philadelphia. (2) The Importance of the Study of Medical Sociology. Charles McIntire, Easton, Pa. (3) Title to be announced later.* C. C. Bombaugh, Baltimore. There will probably time at the meeting for the reading of two or three papers more than are now on the programme. Fellows who desire to contribute such papers are requested to send the titles to the Secretary.

SALOPHEN, THE NEW REMEDY FOR ACUTE RHEUMATISM, is described by several writers as having given very satisfactory results in this condition, without causing the gastric perturbations so commonly observed in active anti-rheumatics and without including toxic phenomena of any kind. The doses administered varied from 45 to 120 grains daily, given fractionally from four to six times within ten or twelve hours. An advantage of the remedy according to several observers lies in the fact that it can in all cases be given in sufficient quantities to produce a useful effect. In cases in which very marked febrile symptoms occurred conjointly with the other phenomena they came under control in from sixteen to thirty-six hours. Some practitioners used salophen and phenacetine in equal parts in those cases of articular rheumatism in which the pains were especially severe. The influence upon the inflammatory processes is described in all cases as having been well marked. In several instances salophen was given in powders with bicarbonate. Golamann's method of administration was to give the remedy by itself on the tongue or in tablets made with starch and sugar of milk. The chemical composition of salophen being in fact a form of salicylic acid, with a non-toxic combination of phenolic acid, would have led any experienced practitioner to expect from this remedy the results which have recently been obtained. Of the value of salophen in influenza there is already a considerable amount of evidence. For this condition it is often united to phenacetine.

THE PAN-AMERICAN MEDICAL CONGRESS. SECTION ON DISEASES OF CHILDREN.—The organization of this Section is completed, and the work of arranging a programme is well advanced. Numerous valuable

*Some of the papers are promised provisionally and are announced with this understanding.

papers have been promised, and the success of the meeting is assured. Physicians interested in diseases of children are cordially invited to attend these meetings, which give promise of great interest both to the specialist and the general practitioner. Any American physician desiring to read a paper will please communicate at once with the Secretary, who will be pleased to furnish all needed information. Executive President: Dr. John M. Keating, Colorado Springs, Colorado. Secretaries: Dr. F. M. Crandall (English-speaking), No. 113 W. 95th Street, New York, N. Y.; Dr. Damaso Laine (Spanish-speaking), Media, Pa. Honorary Presidents: Dr. S. S. Adams, Washington; Dr. A. D. Blackader, Montreal, Canada; Dr. Samuel C. Busey, Washington; Dr. Charles Warrington Earle, Chicago; Dr. F. Forchheimer, Cincinnati; Dr. L. Emmet Holt, New York; Dr. A. V. Meigs, Philadelphia; Dr. W. P. Northup, New York; Dr. J. O'Dwyer, New York; Dr. C. I. Putnam, Boston; Dr. T. M. Rotch, Boston; Dr. J. Lewis Smith, New York; Dr. Louis Starr, Philadelphia; Dr. J. E. Winters, New York; Dr. Jesus Valenzuela, City of Mexico, Mexico; Dr. I. N. Love, St. Louis, Missouri. Advisory Council: Dr. Wm. D. Booker, Baltimore; Dr. Augustus Caille, New York; Dr. Henry D. Chapin, New York; Dr. J. P. Crozer Griffith, Philadelphia; Dr. M. P. Hatfield, Chicago; Dr. Thos. S. Latimer, Baltimore; Dr. J. H. Ripley, New York; Dr. August Seibert, New York; Dr. Charles W. Townsend, Boston; Dr. Jerome Walker, Brooklyn; Dr. Wm. Perry Watson, Jersey City.

Special Notices.

PAINFUL MENSTRUATION.—It is questionable whether menstruation was designed to be painless. At any rate, ninety per cent of all women suffer more or less at almost every period. Diviurnia will in every case give relief, and often cure by its tonic effect upon the uterus. Formula on each bottle.

I am happy to state that **CACTINA PILLETS** have been invaluable in my hands, especially in the treatment of long-continued fevers, such as typhoid. Their action on the heart was most marked in a case of typhoid, patient sixty-eight years old. I used them during all the stages of the disease to keep the heart right; and they most certainly do this. Tobacco heart, as others have found, is most amenable to their influence.—**JOHN S. BOOTIMAN, M. B., B. S., 6 Havelock Terrace, South Shields, Eng.**

I find Peacock's Bromides of great service in **UTERINE CONGESTION.**—**JOHN MATHER, L. F. P. S., Haddington Laboratory, Haddington, Scotland.**

IN THE TREATMENT OF NERVOUS DISEASES AND GENERAL DEBILITY, McArthur's Syrup Hypophosphites demonstrates its restorative powers. Here it is not the stimulating action of the remedies usually classed as tonics that is needed. The organic powers of the system are already taxed to their utmost ability to carry on the physiological processes of life. The Hypophosphites of lime and soda gives the much-needed effect in these conditions—not that of a stimulant by irritation, but that of a true nutriment to the starving tissues. Its tonic effects are permanent, as they are the effects of a richer blood supply bringing health, food, and oxygen to the tissues. Thus the patient is gradually brought up to his normal condition.

THE AMERICAN PRACTITIONER AND NEWS

"*NEC TENUI PENNÂ.*"

VOL. XV.

LOUISVILLE, KY., JUNE 3, 1893.

NO. 11.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

CONSERVATIVE SURGERY OF TO-DAY IN OBSTETRICS, ABDOMINAL, AND PELVIC WORK.*

BY J. G. CARPENTER, M. D.

A diamond in the rough is none the less a diamond, and when from the lapidary shines with more beauty and brilliancy than ever before. Crude midwifery is a thing of the past, yet, like the diamond, midwifery has been refined and perfected by the surgeon until the technique of obstetric surgery has reached definite limits, magnificent proportions, beautiful and perfect results.

When we survey the past, then behold the present status of conservative surgery, doubt has turned to a joyful reality; we see a beautiful drama, our admiration is excited to the utmost, and we exclaim: "Oh, skilled surgeons, live forever!"

Every county, yes, town, of a population of one thousand, should have one or more first-class surgeon or obstetrician, educated, prepared, and equipped to do abdominal and pelvic work; for diseases of the abdominal and pelvic organs and cavities occur in the country as well as in the cities, and as frequently in proportion to the number of population. Trained nurses, surgical armamentarium, aseptic rooms, beds, linens, and furniture can be as easily obtained in the country as in the city. Therefore let us be ready and watchful, patiently awaiting the golden opportunity to save life, restore health, rescue our patients from a premature death and grave. We thus become benefactors to the

*Read before the Kentucky State Medical Society, May 10, 1893, Frankfort, Ky.

human race, ornaments to the profession, show much skill, and keep delay, temerity, ignorance, opium, and dirt out of the way.

The most useful physician to any community is, as a rule, the obstetrician; his skill and attainments should not be second to nor inferior to those of any other physician. He should be ever ready and equipped to meet any emergency; even remove a fibroid, pus-tube, or do a Porro or Snger cesarean section. To the physician who has prepared himself with former training, apprenticeship, and equipments the task is easy when demanded.

Practical obstetrics in this day and time of rapid progression means far more than examining the os, catheterizing the bladder, emptying the rectum, expelling the placenta, ligating the cord, and applying the binder.

When a woman becomes pregnant she should be under the watch-care of a competent physician, and be examined from time to time, sufficiently to keep the blood, brain, spinal cord, and other nerve centers, liver and kidneys, and other organs in a normal state. Complications should be anticipated and prevented; neuroses or reflexes abated.

Microscopic and chemical examination of urine is highly essential in many cases to detect and arrest structural changes of kidneys, eliminate impurities, and prevent puerperal convulsions.

Should sight be impaired, an ophthalmoscopic examination should be made to confirm the presence of intra-ocular lesions, and to direct treatment; to arrest, remove, and prevent further lesions, if necessary, or to induce premature labor to save eyesight.

Digital and conjoined manipulation ought to be made in order to ascertain the presence or absence of growths in the abdomen and pelvis; normal and abnormal position of uterus, tubes, and ovaries; also presence of lesions in same, and bladder and rectum; a laceration of cervix or perineal body; position of placenta, position and presentation of fetus, and the existence of inherited dyscrasia, former dystocias in self, mother, sisters, aunts, and grandparents. The rectum and colon must be given special consideration and placed in a healthy state before labor.

The able intrapelvic diagnostician, instead of giving opium or hypodermics for proctalgia, will examine his patient, detect a retroverted or retroflected uterus, restore it to normal position, and retain it with an antiseptic, elastic wool tampon applied from time to time; or to insert a suitable pessary, and have patients wear one or the other

until the uterus ascends beyond the promontory and is self-sustaining, thereby arresting and preventing abortion.

Thorough antisepsis and asepsis must be practiced before, during, and after labor, thereby preventing puerperal infection and ophthalmia neonatorum. The precious narrative of asepsis must be told again and again; many, many do not know it.

Under the head of asepsis and antisepsis we mean free purgation, hot water and lye soap bath, hot antiseptic injection and antiseptic wash for the genital organs, abdomen, and thighs twelve or twenty-four hours before labor; the latter repeated at the first stage and after the third, and subsequently "*pro re nata*." The patient should be clothed with aseptic linens, and pad, bed, bedding, nurse, and accoucheur must be aseptic; the clothing and surgical paraphernalia, room, and furniture must be kept surgically clean. Our results in the salubrious country and country towns, the atmosphere of which always contains an excess of ozone, free from contaminating influences, should equal, if not excel, those of Preston Retreat—no deaths in 1,300 cases of labor.

The country physician deserves all praise, for the best results in cesarean section have been obtained in rural districts and private practice. Lusk states, The habitual indifference of the rural practitioner to the publication of his triumphs is one of his besetting sins; and Stoltz states, A goodly number of successes as well as failures lie buried in the note-books of modest physicians; and specialists in abdominal and pelvic surgery have long ago realized the importance of selecting high, dry, rural districts for private sanatoria, with an abundance of sunlight, foliage, and ozone.

Last, but not least, the obstetrician's work is not done in each case of the puerperium until he has repaired any lesion that resulted from labor, prevented a return of former displacement of the womb, and restored the woman to her former health. And should he do his whole duty, first prepare the patient for the "lying-in period," then try to prevent complications during accouchement, and should they occur repair them at once, women would come out of the "lying-in chamber" sound and healthy. The dangers of delay, ignorance, timidity, prejudice, indolence, and lack of surgical skill, auto-infection, impaired health, and the morphine habit would be avoided; joy, happiness, prosperity, and health would be the patient's weal; and much gratitude, admiration from patients and friends, increase of clientele, reputation, and revenue would be the doctor's great reward. When the obstetri-

cian has done his whole duty, then the abdominal and pelvic surgeons will have far less to do.

Forceps are a blessing to both mother and child; judiciously applied and in skillful hands they prevent lacerations, subsequent retention of urine, urethritis, cystitis, sloughing, and fistula of the utero-genital tract, prevent and arrest puerperal convulsions, shorten lingering labors, and in long-continued, active labor, with violent convulsive pains, prevent rupture of the uterus, and in placenta previa arrest the hemorrhage by bringing down the head for a tampon, and when applied early, preceded by the hand, arrest "posterior occipito-iliac" positions, and make normal ones. When the fetal heart is feeble or inaudible the judicious use of forceps by hastening labor saves the life of the child. The writer has never had a laceration of the perineum in forceps cases, even in primipara; but has had laceration when he did not use forceps, and caused by the shoulder and not the head of the child. Statistics show twenty-five per cent of primipara receive lacerations of perineum.

Yet we often hear general practitioners say that in a midwifery practice of ten or thirty years they never had and never saw a cervical or perineal laceration; they tell the truth in part; they are afraid to look for them, and if found they did not know how to repair them; and patients after an incomplete recovery go to some competent surgeon who does find them and give the proper surgical treatment.

We hope the day has come when the "cervix-feller" and the gynecological "tinkerer" will be no more, and that the words "obstetrician and gynecologist" will stand for the competent, skilled, and equipped abdominal and pelvic surgeon.

A lady once said she had no fears concerning her labor, as her obstetrician was also a good surgeon. By knowing the former history and the present condition of the patient from conception to the end of gestation, the surgeon by digital and conjoined manipulation knows the possibility or impossibility of a natural labor before parturition sets in, and is forewarned, forearmed, and ready, the patient in every particular prepared and ready for the ordeal of normal, instrumental, or premature labor, and also, if necessary, for abdominal section (celiotomy), either the Porro or Sanger cesarean operation or symphysiotomy. If the patient's condition is known before accouchement, and she can not be delivered *per vias naturales* (except by embryotomy), she in competent hands is saved a long, tedious, exhausting, and dangerous labor, and by asepsis and surgical interference her life

and that of the fetus are saved through abdominal section. In regard to the "elective cesarean section" Coe affirms, "The two elements of success are early operation and perfect technique;" and adds, "My experience entirely accords with the position taken by Harris, that, other things being equal, we increase rather than diminish our chances of success by operating before the commencement of labor.

Operate early, and you give both patient and surgeon every possible advantage. The elective operation should be made such in every sense of the word. It should be subject to the same rules which govern ovariectomy or abdominal hysterectomy. Let the surgeon choose his own time, near the end of pregnancy but before labor has begun, confident that he is thus acting for the best interest of both the mother and the child. Hemorrhage need not be feared. The danger of shock is lessened. Sepsis is eliminated.

The success of Drs. Joseph and Mordecai Price, Charles P. Noble, Wm. T. Lusk, Howard Kelly, and Grandin in elective cesarean section confirms the above statements. Ten operations reported since 1889 have been *practically elective*; that is, they were performed as a substitute for embryotomy, and *they were all successful*. (American Journal Gynecology, January, 1893, Col.)

Indications for cesarean section are, deformity of pelvis with contraction of its diameters one half or two inches, tumors of various kinds blocking the pelvic outlet, from abdominal and pelvic organs or from the bony pelvis, malignant disease of cervix, and impaction of the fetus transversely across the pelvic brim may, under special consideration, be an indication for cesarean section. (Grieg Smith.)

The general practitioner, as a rule, is the first to meet an appendicitis or pericecal inflammation. Upon his early diagnosis hangs the life and destiny of the patient. It is incumbent upon him to give the "danger signal," "beat back the breakers," and with the surgeon's assistance land the "leaking barque" into the "haven of rest." If the surgeon is called early it means the saving of a life, short convalescence, removal of dangers that daily menace health, happiness, and life, a minimum of shock, short anesthesia, and two to three per cent mortality—a most beautiful picture to behold!

Simple recurrent appendicitis is a constant indication for section and appendisectomy. Ulcerative appendicitis, with or without perforation, though inclosed in thick lymph walls and adhesions, is a most cogent reason for section, for no physician knows when the lymph wall

will soften, break down, leak, and produce purulent peritonitis, or the bands of lymph or adherent appendix constrict the lumen of the bowels and cause intestinal obstruction.

There is such a thing as a patient having only one attack of appendicitis (the case ending in recovery), but the cause would be the escape of the foreign body (appendolith), into the cecum, as well as the subsidence of inflammation and escape of the appendiceal secretion. By discharging its contents the appendix may atrophy after subsidence of the inflammation, and be converted into a cord-like body, no longer a source of trouble and danger. Rest, hot fomentations, free purgations, and astringent anodynes often seem to and do cure, but in recurrent cases never, but blindfold the victim and lead him over the precipice to his destruction.

When these symptoms subside, but return again, it is as a black cloud hanging over the patient, urging the physician to call the surgeon before it is forever too late, for, on the advent of another spell, ulceration with perforation and peritonitis are likely to take place, or a pericecal abscess may become encysted by lymph walls and powerful adhesions, which latter may give way or leak, and produce purulent peritonitis and death. Yet life could be saved by section. "When celiotomy is done before perforation the abdominal cavity is aseptic, the technique of the operation in all its details is aseptic, and the procedure becomes a life-saving measure, both conservative and curative, and prophylactic against future invasions of pericecal mischief." (Senn.)

The writer in his own practice has to record two interesting, unique, and illustrative cases of traumatic pericecal inflammation saved by judicious and timely section. One physician's diagnosis had been "hip-joint disease," another "typhoid fever." The temperature was 103.5° , pulse 130. An anesthetic was administered, and minute physical examination revealed pericecal abscess, which was trying to work its way to the surface, and empty. The tumor was prominent, and could be mapped out distinctly and fluctuation elicited. Section, irrigation, and drainage saved the boy's life. Temperature and pulse were normal in twenty-four hours. The boy made a rapid recovery.

In another case tumor was detected in the cecal region. The boy was declining rapidly. Temperature was 102° , pulse 130. Section, irrigation, and drainage saved the boy's life. This case simulated remittent fever.

Dr. Joseph Price said he would make no delay by taxis for the reduc-

tion of stangulated hernia, but operate at once for its relief, and for the radical cure. Wyeth states: "Do not wait longer than the lesion of intussusception is recognized; within the first twenty-four hours the prognosis will be more favorable, and the danger of a fatal termination will be increased each day thereafter."

That taxis should not be done longer than five or ten minutes at any one effort, and that it may be repeated at intervals of half or one hour within the first six hours of the history of strangulation, and after twelve hours should not be practiced. "The majority of the cases which end fatally are those in which strangulation had existed twenty-four hours or more, and before surgical interference. Scientifically practiced massage and taxis have a limited range of application in the treatment of intestinal obstruction, are applicable to cases of obstruction due to a foreign body, an enterolith or fecal accumulations, and should only be resorted to before inflammatory changes have developed at the seat of obstruction and while patient is under anesthesia." (Senn.)

The rule now is, not to wait hours or a day to do taxis, but to do it only fifteen minutes, and never over thirty. Senn says true intestinal obstruction, whatever its cause may be, is as strictly a surgical affection as strangulated hernia, and remediable only by the same kind of surgical treatment. "To let a patient die of the consequences of a removable cause of obstruction without an operation is a reflection upon the advance of modern aggressive surgery."

The "menopause" does not arrest the growth of very many fibroids, they do grow and increase in size after this period, or undergo calcareous, fatty, cystic, or cancerous degeneration, or suppurate and take on gangrene. They kill by hemorrhage, pressure, and exhaustion, and if their removal is delayed they degenerate into cancer and quickly kill the patient.

Celiotomy for an uncomplicated ovarian tumor is one of the easiest and simplest operations in surgery.

The extra peritoneal method of removal of fibroids in expert hands has become one of the most feasible, successful, and safest operations in surgery. The pedicle as made by Dr. Joseph Price is quite small, not larger than the thumb; remains aseptic, mummifies and dries up without suppuration. Yet the intraperitoneal method of treating the stump with ligation of ovarian and uterine arteries, with apposition and suture of the peritoneum over the stump, has been successful in the practice of Bær, Kelly, and others.

Hemorrhage and leucorrhea from the endometrium after the "meno-

pause" are highly indicative of carcinoma (other factors being eliminated), and especially if a cancerous diathesis exists, a mother, sister or aunt having had cancer, are justifiable grounds for vaginal hysterectomy though no other diagnostic symptom is present.

Specimens examined in the past from former cases proved the presence of incipient and insidious cancer of the fundus. 103 supravaginal hysterectomies with seven deaths, and 66 vaginal hysterectomies with three deaths, prove these statements in the practice of Dr. Price.

No case of ectopic pregnancy should be allowed to die for want of section in this day and time, even in rural practice. While the physician can not make the diagnosis *per se* in every case, yet there will be enough symptoms present urging and demanding section as a conservative, life-saving measure. The wise and able physician will make the diagnosis and operate, or have a surgeon called and section done at once. Eighty-three cases of ectopic pregnancy, with only three deaths, by Dr. Price, prove most of the cases can be diagnosed and saved by judicious and timely celiotomy. Section for placenta previa, Dr. Price states, is sublimely ignorant obstetrical counsel, or a criminal practice or suggestion.

Greig Smith states: Removal of the uterine appendages is performed for local disease in the ovaries and tubes, and has a three-fold purpose:

1. To remove organs incurably diseased, the ovaries and tubes causing danger to life or serious disability, abscess of ovaries and tubes, recurrent salpingitis with hematosalpinx and hydrosalpinx. Fallopian pregnancy and strangulated ovarian hernia endanger life; cystic disease of the tubes, ovaries, the more chronic and subacute inflammation of ovaries and their displacement cause disability in varying degrees.

2. To check or modify the discharge of blood from the uterus, it being excessive in amount attended with danger or great pain. Uterine myoma is attended with profuse metrorrhagia, and cystic ovaries with profuse and uncontrollable menorrhagia. Incurable obstruction in the vagina or womb to the menstrual flow causes pain and danger; malformations and malpositions cause so much pain at menstrual periods as to render life a sort of recurrent martyrdom.

3. In a small and diminishing class of cases a profound neurosis mania. Mania or epilepsy may under very special restrictions be quoted as an indication to operation; yet even in these cases with a curious frequency disease of the organs is found at operation. The essential concomitants of these diseases must be of a grave nature; there must be danger to life or serious impairment of health before operation is contem-

plated. Six cases of mania were operated on for diseased appendages at Norristown Insane Asylum and Female Department by Dr. Alice Bennett and Dr. Joseph Price: three recovered their minds, and are at home sound and well; one greatly improved, changed from a dangerous and violent maniac to harmless tranquility of mind; one, hystero-epilepsy, no improvement; one died of septic peritonitis.

Several members of the Central Kentucky Medical Society have successfully done celiotomy for appendicular disease, intestinal obstruction, intestinal resection, and intussusception, diseased tubes and ovaries, suprapelvic hysterectomy and cystotomy, vaginal hysterectomy, ectopic pregnancy, fibroids, and ovarian tumors, and stab and gunshot wounds of the abdomen. Yet some specialists in the cities claim that abdominal and pelvic surgery can not and ought not to be done in the country districts, especially of Kentucky.

In doing an abdominal section the aim of the surgeon should be to save life, remove incurable disease, operate quickly, safely, and cautiously, and not do an ideal operation, but economize time, minimize shock, lessen the stage of anesthesia, prevent hemorrhage, unnecessary extrusion of bowels, and protect them with hot aseptic towels, irrigate with hot aseptic water, and prevent complications, making all the details of the operation aseptic from beginning to end. Diagnose all tumors of the abdomen and pelvis early, and operate at once while the patient is in the best health, the tumor small, and before structural lesions have taken place in adjacent and remote organs.

Hindrances to the progress and success of abdominal and pelvic surgery have been due to the delay, ignorance, timidity, and abuse of opium on the part of the physician, he not sending the patient in time to the surgeon, and by the timid surgeon failing to operate and remove the lesions the operation demands.

Time waits for no surgeon! "Delays are dangerous." "Procrastination is the thief of time." Delay, ignorance, timidity, opium, and dirt kill patients, and not surgical skill. The best time to operate is when the diagnosis is made, and made early. These aphorisms must be proclaimed here and in every medical society; yea, they should be proclaimed from the house-tops to the people.

In conclusion: The day of the ignorant midwife, the medical pretender, the incompetent graduate of second and third-class medical schools is over. The surgical millennium has come.

CONSTIPATION.*

BY CORNELIUS SKINNER, M.D.

Of all the minor troubles to which the attention of the practitioner is called, I am persuaded that constipation is the most common, and, I am equally bold to say, the most intractable in its cure. It is my purpose in this short paper not to treat of constipation in all its forms, but to take up that one in which constipation seems to be the disease and not the symptom. Stricture, fissure, hemorrhoids, spinal lesions, tumors, etc., will not be spoken of, but rather that form in which we find tardy and difficult defecation with hard scybalous stools. We will not use the time in rehashing the symptoms and effects in general, but go direct to the form in question.

A large majority of these patients we find among the women, and usually at from fifteen to thirty years of age. The usual chain of symptoms are given, and on casual questioning we find that they have had time for and paid more attention to every thing else in life than to the bowels. They are punctilious in all engagements, regular at meals, etc., but not at stools, the most trivial affairs, social and otherwise, causing a postponement of one of the most important calls of nature to a more convenient season, which is usually the next day. Again, we find not all typewriters, teachers, etc., or people who lead a sedentary life, but just as often floor-walkers, postmen, or those who take a great deal of exercise with good digestions and appetites sufficient. One thing is noticed in I might say all this class, and I consider it the prime cause of all the trouble, viz., these people do not drink a sufficient quantity in twenty-four hours for nature's demands. They are noticeably small drinkers, and never take water unless prompted by thirst or at meals, and then will drink to excess. The majority of people in general drink too much while eating, thus diluting the juices of digestion to a degree which will eventually impair digestion. It is not easy for us to realize the amount of water thrown off by a healthy man or woman in twenty-four hours. By the kidneys we lose 42 ounces; by the lungs we lose 23 ounces; by the skin we lose 15 ounces. Now contrast this with the amount taken in during the same time, and we find little enough left for the bowels under most favorable conditions, and when we lessen this by one fourth or one half, we find nothing left to

* Read before the Louisville Medico-Chirurgical Society, April 14, 1893. For discussion see page 420.

keep the stools soft and in the proper condition to be by peristalsis packed down into the sigmoid ready for prompt and easy expulsion.

Constipation may be called the machine of "perpetual motion," for when once started it perpetuates itself until checked by proper causes. Now, I admit that we must find the cause for all things, and then remove that cause in order to effect a cure, and, in this very common form just spoken of, to relieve it, we have simply to furnish that deficiency of water in the proper way, and the cure is effected.

It is my custom not to employ any of the waters now sold for constipation; first, because they will not cure but establish in the bowel that habit, which we want to avoid, of waiting to be driven into action by laxatives; secondly, they are expensive.

As I have said before, this water should not be taken at meals, nor too close to the meal hour, but long enough before in order that it may have time by absorption and otherwise to pass out of the stomach into the circulation and bowels below. I have the patients to drink an ordinary tumbler full of cold water thirty minutes before breakfast, dinner, and supper, and to take the fourth at retiring, giving xvi oz. or Oj in addition to that taken at meals as coffee, milk, or tea, and during the day when thirsty. Except in very obstinate cases this simple remedy gives me most gratifying results. In those intractable cases I generally use the little pill of aloes, belladonna, strychnia, and podophyllin each night, or less frequently during the week as the exigencies of the case require. There will be failures on the part of the water and much disappointment to a few patients who put their trust in this remedy, but if this plan is followed systematically, in from two to six weeks we will get good results. As an apparent exception, I wish to mention a case of constipation that has given me no little concern in the past three weeks.

Patient a tall, slender woman, raised in the country, of good health and family history; age thirty-nine years; married about two years; baby five months old. The woman first consulted me in the beginning of gestation for nausea and a small tumor in the left groin just about the site of inguinal hernia. No positive diagnosis of tumor was made, but I assured her that it would play no part in her confinement, and advised leaving it alone, there being no pain or other symptoms to attract attention. Constipation during and after gestation remained quite a factor, which was tolerably well controlled by the water treatment with the addition of a small glass of Hunyada water before break-

fast. On the night of March 21st I was called, and found her suffering intense pain just over the symphysis and tumor mentioned; pain did not intermit but was continuous; tumor very sensitive to touch; almost constant nausea. My first impression was strangulated hernia. Bowels had moved in the morning after the water was taken, pain began at 5 P. M., and this was 11 P. M. Usual domestic remedies had no effect; pulse 75, temperature 98.5° F. After watching the pain for an hour and still hesitating between strangulated hernia and colic, and realizing the importance of a positive decision, I called Dr. Rodman in consultation. The doctor meeting me in one hour, pain in the mean time had shifted into the epigastric region and had become much less. This changed the aspect somewhat, and we both concurred in its not being strangulation but colic. We concluded our visit at 3 A. M., but left a hypodermatic of morphia and atropia to be given by the husband if the pain grew worse. I saw the patient next morning at nine o'clock; she was comfortable but much nauseated; pulse 75, temperature 98.5° F. Nausea lasted all day and following night. On the morning of the 23d still great nausea, pulse 100, temperature normal; hot water ordered, which controlled nausea. Met Dr. Rodman on the street, and we agreed to give calomel in one-grain doses until bowels were moved, or six grains had been taken. At 2 P. M. pulse 110, temperature normal; patient very restless and slightly flighty; calomel was begun. Dr. Rodman saw her with me at 10:30 P. M. Pulse 120, temperature normal; restlessness increased with very marked flightiness; no movement from bowels. We now believed that there was some internal obstruction, and so expressed ourselves to the husband, and at the same time decided to open the abdomen in the early morning if there was no change for the better. This he very positively sat upon, because her mother living in the country was not here to counsel. However, we felt that all responsibility had been assumed by the husband.

Expecting to find the patient worse by morning, we left, but with the determination of going back early and prepared to operate at once. Drs. Mathews, Cecil, and Bullock were asked to meet us. We met at 8 A. M., 24th, to find pulse 100, a drop of 20, temperature 98.5° F., no restlessness, and patient much better. Since the mother could not reach the city before 7 P. M., we all decided to wait. Patient held her own until the 30th, when nausea again appeared, with pulse 120, and temperature 99.5° F. Calomel was given in doses of one grain every hour for six hours, but with no effect. On the afternoon of April 1st

castor oil in one-dram capsules was given every two hours, to be kept up until bowels moved, or eight were given. After twelve hours bowels moved copiously, and thus ended to us a most puzzling case.

It is proper to say that frequent colon irrigations were made by myself with and without glycerine.

The point I want to make in the paper is that in this class of cases, where we find no especial reason for the constipation, water given in the manner described will result in a cure in most of them. The results of this treatment in my practice have been most gratifying.

LOUISVILLE.

**IN MEMORIAM: CHARLES HARVEY SPILMAN, OF HARRODSBURG,
KENTUCKY.***

Born, May 20, 1805; died, December 15, 1892.

BY A. D. PRICE, M. D.

A friend and brother has passed away; his familiar form will no more grace this assemblage; his voice, earnestly pleading for truth, has been heard among us for the last time. In this tribute to the memory of him whom we admired for his integrity and his devotion to his chosen profession I have noted many incidents of his life that will be pleasing, if not instructive, to the members of this Association, and for which no apology is necessary.

Benjamin Spilman, a native of Virginia, married Nancy R. Rice, of the same State, in 1791, and immediately emigrated to Kentucky, locating in Garrard County, where Charles Harvey Spilman, the subject of this memoir, was born, May 20, 1805.

His parents moved to Muhlenberg County in 1806, thence to Livingston County, in 1816, from there, in 1820, to White County, Illinois, and finally, in 1833, they settled on a farm near Hillsboro in that State, where they lived in peace and comfort, and where many years were added to their lives.

His parents were Presbyterians, his father an elder; and so faithfully did they train their children in the faith that all of them became Presbyterians—three sons ministers, and the subject of these thoughts an honored officer in his church.

*Read to the Central Kentucky Medical Association, at Stanford, Ky., April 19, 1893.

Boy-like, he was at times wayward and reckless, and among his earliest recollections was the necessary correction administered by loving parents in old Presbyterian style, with stripes and prayers.

At an early age he was sent to a country school, walking two and a half miles. He was not fond of his books; but by the aid, comfort, and encouragement of a kind and loving mother he was enabled to stand at the head of his class. He was no exception to the rule, that every boy owes a debt of gratitude, that can never be paid, to the loving and self-sacrificing being who bore him.

At that time only the favored few could pursue their studies uninterruptedly. He was not one of that privileged class, so he had to work on the farm and gain knowledge the best way he could. This life of labor and study continued till his twentieth year, when, having a reasonable knowledge of English and a smattering of Latin, he taught school for one year. During this time he had his first love experience, with the usual result; an affair to which all men fondly recur with a thankfulness that a kind Providence rules their destiny.

He now went to the High School at Vincennes, Indiana, where he was pupil and teacher for a year. Here he met an old gentlemen whose generosity enabled him to enter Centre College, Danville, Ky., in 1827, where he remained two years, when his failing health compelled the abandonment of his collegiate course. His leisure moments while at college had been spent in the compilation of church music, which was published in book-form during the winter of 1829-30.

The spring of 1830 finds him principal of the Nicholasville Academy, where he taught for two years, during which time he began the study of medicine under Dr. Berry. In 1832, having been prostrated by repeated pulmonary hemorrhages, he removed to Yazoo City, Miss., where he engaged in the practice of medicine with his brother, Dr. James Spilman. In 1833 he entered Transylvania University; the following spring he returned to Yazoo City and resumed practice, and was instrumental in establishing the first Presbyterian Church in that place. He returned to Transylvania in the fall of 1834, and the following spring received his degree. April 9, 1835, he married Miss Mary Skillman, of Lexington, Ky., who made him a loving and devoted wife. He was now invited to become editor of a religious newspaper to which he had been a frequent contributor, but declined, deciding not to abandon his profession. So, with his loving bride, he started life anew in Nicholasville, in which place and at Keene he practiced his profession

till 1850. During the first thirteen years of his married life there were born to him ten children—three girls and seven boys. His first sad affliction came to him in 1842 in the death of his oldest daughter. Subsequently the Angel of Death was a frequent visitor, and one by one the loved ones departed.

In January, 1850, he moved to Harrodsburg, where he lived many years, an honored physician and a respected citizen. In May, 1850, he attended the meeting of the American Medical Association, held at Cincinnati. Thus began his love for organized medicine, which continued to grow and develop throughout his long and useful career.

In October, 1851, he assisted in the organization of the Kentucky State Medical Society at Frankfort, and reported at its next annual meeting, which was held at Louisville, upon the Indigenous Botany of Kentucky.

At the meeting of the Society held in Covington, in 1854, he presented an essay upon Suits for Malpractice, and was honored by being made its president.

At the meeting of the Society held at Bardstown, in 1860, he read a paper upon the Medical Biography of Kentucky, it being the first report of that kind made. The subjects of the biographical sketches were Drs. Philip Trapwall, John A. McBrayer, and John Bemiss. After this meeting the Society did not again assemble till the Civil War had closed.

Realizing the responsibility of his profession, and sympathizing to a marked degree with the afflicted, he was ever trying to prepare himself for the more efficient discharge of his duties. With this end in view he was a constant attendant at his medical societies, willing to impart and anxious to receive information. He underwent a large amount of labor and endured many personal sacrifices, and consequently was at times in such a state of feverish anxiety as to doubt if he had not made a mistake in the choice of his profession. He always responded to the calls of humanity, and for the first twenty-five years of his professional life never turned a deaf ear to the humblest suppliant. He had no special fondness for surgery, and his practice in this department of medicine was limited.

The following are the operations he performed:

Amputation—Of hands, 1; of forearm, 2; of arm, 1; of leg, 1; of thigh, 2. Operation—Trephining, 5; fistula in ano, knife, 7; fistula in ano, ligature, 4. Delivery—By section, 1; by forceps, 17; by perforation, 8.

As a general practitioner he was painstaking, kind, and affectionate, and won the love and respect of those to whom he ministered. In 1852 he was tendered the chair of obstetrics in an eclectic school, but declined because he considered that branch of the profession exclusive, ignorant, and empirical, thus emphasizing that honesty and integrity of purpose that characterized his professional life.

In 1861 he was offered the chair of materia medica and therapeutics by one of the regular schools of Cincinnati, but declined because he did not feel competent to discharge its duties properly—once more his claims for honesty stood out boldly.

Loving his country, and recognizing the good and the evil of the contending sections, he heard with the profoundest sorrow the rumblings of the Civil War. During the fratricidal strife he lived under a cloud, fearing that the grandest of governments, the patriot's pride and the freeman's hope was doomed. When the end came and the Union was saved he was grateful, but was disturbed by the negro question, and solved the problem in his own mind by colonization.

His oldest son returned from the war broken down in health, and soon died. Misfortunes come not singly. He was robbed of his children one by one, and finally his wife was taken, leaving him only a son and daughter, who survive him.

This Association knew him best as its first president, and as a faithful and efficient member from its organization till infirmity rendered his attendance impossible. He never shrank from his duty, and was always at his post, contending for the opinions formed and the theories elaborated throughout long years of thought and study. Thus he met his Fellows in debate, giving and receiving, contending for what he believed to be right, and seeking only truth.

A grand old man, devoted to his life-work, with an energy that often urged him beyond physical endurance, he set an example worthy to be imitated by every follower, old or young, of the healing art.

His active professional life being spent at a time when professional morals were not the best, he was placed in many trying and vexing situations, but was never known to be guilty of an unprofessional act or to do any thing that tended to lower the dignity of his profession. He lived an honorable and useful life, respected by the community in which he lived and died, mourned by all who knew him, at the home of his daughter in Hopkinsville, Ky., December 15, 1892.

Reports of Societies.

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.*

Stated Meeting, April 14, 1893, Dr. F. C. Simpson, President, in the chair.

Dr. F. C. Wilson: (Stenosis of the Esophagus.) This specimen is from a patient, male, aged about fifty-seven years, who had always been perfectly healthy, that is he had never been under a physician's charge, although never robust in appearance. He commenced having some difficulty in swallowing, which gradually increased to such an extent that he became uneasy about it, and he began at the same time to vomit. He never had any severe pain of any sort; gave no history of having swallowed any poison or corrosive substance, and was of course at a loss to account for the trouble. When I saw him I found he was able to swallow liquids, but in an irregular way. Sometimes he would be able to swallow them for a day or two, at other times for some days he would hardly be able to get any thing down. When any thing would pass down, after a while a good deal of it would be regurgitated. He gradually grew worse until he was considerably emaciated. I questioned him concerning his symptoms, as to the possible inheritance of cancerous trouble, as to his having swallowed any substance like a piece of bone, or any corrosive material, but found that he gave no history of any thing of that nature. I could locate by auscultation some obstruction during the act of swallowing near the lower end of the esophagus; I could hear it distinctly as he would swallow while I listened over the course of the esophagus. I suggested to him that I explore the esophagus, at the same time pass any obstruction that might be there by means of the bougie or feeding-tube. During auscultation I listened carefully for evidences of aneurism or bruit, thinking there might possibly be some obstruction due to that, but nothing of the sort could be heard. The patient complained of no pain such as we usually find in aneurism occurring in proximity to vertebral column; we know that gives rise to severe boring pain due to breaking down of these vertebræ by impact of the developing tumor. Nothing of the kind could be elicited in the history, and there was no evidence of any aneurismal enlargement.

*Stenographically reported by C. C. Mapes, Louisville.

I made an engagement with him and visited him for the purpose of introducing a tube. He was a very timid and nervous man, and I had some difficulty in passing the tube, but I could distinctly recognize the obstruction when that point was reached. I succeeded in passing an ordinary rubber feeding-tube and poured through it a fairly good meal of milk, and after that for several days he was able to swallow with a great deal more ease. I made another engagement with him for several days later, but before the time was reached he sent word that he was swallowing so much better he believed he would postpone it. I saw no more of him, and six months afterward I saw notice of his death. He passed into the hands of some homeopathic physician; he grew gradually worse and more emaciated, and finally death occurred from exhaustion. I was called to make a *post-mortem* in the case. I made the autopsy and secured this specimen, which I present here to-night with the idea of getting the opinion of the Society as to the nature of the enlargement. No microscopical examination has been made thus far. In making the *post-mortem* examination I opened the chest and found no trouble to account for death until I reached the esophagus. I removed the entire mass, esophagus and stomach, and in slitting open the esophagus I found near the lower extremity some excrescence-like growth which involved the lower portion of the esophagus and extended through the cardiac orifice into the stomach. This enlargement or growth looked very much like an excrescence, not nodulated and not hard. The stomach was very much contracted. There was no involvement of the neighboring organs, of the liver or spleen. I believe Dr. Coomes saw the case a number of times and passed the bougie, but what his opinion was as to the nature of the trouble I am unable to say. One homeopathic physician who saw the patient, I think, made diagnosis of aneurismal enlargement of the aorta. Nothing except a careful microscopical examination can clear up the exact nature of the case.

DISCUSSION.

Dr. J. A. Larrabee: I have had quite a number of cases of stricture of the esophagus covering my experience in practice, eight or ten probably. I have one now that I would like to turn over to the homeopaths. I think this is a capital idea. The patient referred to came to my office about two weeks ago; I started in by passing an Oliver bougie, smallest size. After three dilatations in that way I passed the larger one, which is the largest size of four bougies in the set manufactured by Oliver. I

told him I thought that amount of dilatation would give him some relief, and fully expected it to do so whether it was temporary or otherwise; but, contrary to my expectations, he reported it was no better an hour afterward, so far as swallowing was concerned, than it was before. I scraped some of the material from the tube after withdrawal and handed it to Dr. Vissman for examination. The patient is not emaciated and presents a very fair appearance. There is no cancerous cachexia, neither has he a cancerous history. Now, I believe this man is going the way of the other case of stricture of the esophagus reported, but just what the nature of the stricture is I do not know. The case has only been under my observation for two weeks, and he has been unable to swallow any thing except fluids. Auscultation locates the obstruction about midway of the esophagus; you can hear it "chuck" there just as plainly as you could in a bucket, then the fluid slowly trickles down.

Dr. A. M. Cartledge: It seems to me in cases of this character the first thing to establish is "stricture of the esophagus;" after that fact has been once established usually there is but little difficulty in determining the nature. Certainly there should be very little trouble after death has taken place. It seems to me differentiation should be very easy. True stenosis of the esophagus is cicatricial or malignant. Cicatricial stenosis is the result of syphilitic ulceration, more rarely tuberculous, and very commonly the result of trauma.

In the case reported by Dr. Wilson, without a microscopical examination I do not think any one should pass a judgment, but my opinion is that it is clearly malignant disease. It is not syphilitic, it is not tuberculous, and I take it from the size of the deposit and the macroscopical appearance that it is carcinoma, and believe that the microscope will prove it.

Dr. Larrabee: Would it be possible, if it were carcinoma without any ulcerative stage set up, to have told from the secretions whether it was cancer or not?

Dr. Wm. Vissman (visiting): I do not think there is any possible way of telling whether it is cancerous or tuberculous, or any thing else, unless you get a particle of the tumor, and you could not get this without there was a breaking down.

Concerning the specimen exhibited by Dr. Wilson: From a macroscopical examination I think there is no doubt about its being a carcinoma. One peculiarity about the tumor is that we can not discover the

exact line of the stomach; that is, where the stomach has been taken off. Another peculiarity is that carcinoma of the esophagus very seldom, or never we might say, extends into the stomach. It may be that the microscope will show that this is nothing more nor less than a carcinoma of the esophagus.

Dr. Wilson: I had mapped out a plan of management of the case which possibly may have had something to do with scaring him off. I had spoken either to the patient himself, or a friend, of the advisability of feeding him in the way that I had attempted to do; and, if that failed, then of putting a tube into the stomach from the outside so that he might be fed in that way. Of course if the tumor proves to be malignant in character it would eventually have caused death, but I believe his life might have been prolonged by the insertion of a tube into the stomach. He was greatly emaciated, and certainly died from sheer exhaustion. Had the tube been inserted in the stomach from the outside, his life might have been prolonged possibly several months at least. (A subsequent microscopical examination of the specimen by Dr. Vissman clearly proves the trouble to have been of a cancerous nature.)

Cornelius Skinner, M. D., read an essay on Constipation. [See p. 410.]

DISCUSSION.

Dr. Larrabee: I do not think a paper as interesting and instructive as the one presented by Dr. Skinner ought to go without remarks. I will say that when I received notification of this meeting and saw the name "Constipation" as the subject of the essay, I felt "bound" to come. The importance of what Dr. Skinner has said in regard to a minor condition becomes in the mind of every practitioner a major condition. The importance attached to the movements of the bowels may be best estimated by the love of people for cathartics. All a man has to do to make his fortune is to get up a cathartic pill or a powder for the same purpose. The desire of the community to be purged amounts almost to insanity. I do not suppose there is a board fence this side of Bullitt County that has not painted upon it something for regulating the bowels. There is not a peak in the Rocky Mountains so high that somebody has not climbed up to put Vinegar Bitters or Carter's Liver Pills on it, so you can judge somewhat of the importance of purgative medicines. Regulating the system and keeping the bowels in a soluble condition can not be overestimated, and I am one of those who believe in the poisonous effects of retained material in the bowels. If we have a

disease called "uremia" from retention of the urine, I do not see why we can not have diseases dependent upon "stercoremia." Many people may have died from causes produced entirely by constipation.

There is one point which has struck me all along while engaged in the practice of medicine, and that is the success of quacks who use nothing else than aloin purificata in the treatment of chronic diseases. You can take it for granted that when a man starts out with patent medicines, medicines which he himself has patented and advertises for the cure of chronic diseases, that he is giving aloetic purgatives; and another fact, that is not sufficiently weighed by physicians in debarring the quack, is that he succeeds in relieving many of these chronic cases. Any old chronic case of any thing, I do not care what it is, whether rheumatism, gout, or whatever it may be, is more or less relieved by a severe purging. That is where the quacks get in their work, they help every case of that nature, old patients, men who have been drinking a good deal. I know of half a dozen cases here where old chronic cases of mine have bought medicines from men who were selling them along the street, the vilest compound ever put up, a decoction of aloes, and horse aloes at that, and every one of them were relieved, and relieved for quite a while.

I speak of this, gentlemen, just to call your attention again to these forgotten facts of our law, where we fail in the course of treatment to secure free daily alvine dejections. We can administer a tonic, we can administer iron, tonics for anemia, spanemia or hydremia, and the iron does very little good; we do not get the reddened blood corpuscles, nor do we get the characteristic effects of the iron. In this particular the iron waters do more good than our iron simply because they combine purgative salts with the iron. It was the custom of the old school to purge, to vomit, and to bleed; this was the circle of therapeutics around which they moved, and certainly they were on the right track so far as purgation, dieting, etc., were concerned. I think we are forgetting a great deal of the dietary system, and our patients would probably be better off if the old regime were adhered to a little more closely. For instance, I see every day cathartics ordered, of different kinds, chologogues, etc., and the patient allowed to eat what he pleases; the old style was to make cornmeal gruel, or oatmeal gruel, and while the patient was being purged he had to take this kind of a diet. Nothing has been said about the idea that constipation is dependent upon the rapid absorption of water from the intestinal tract. The rectum is a

drying machine if it is any thing, and so situated as to prevent our becoming nuisances to ourselves, taking up the water from the rectum and drying the feces in the proper shape. Now those people who are constipated have very rapid absorption of water, unless you force large quantities upon them, which means certain cure; it need not be water laden with medicinal elements—simply water (being sure that it is fresh), and use it on account of its being water, preventing this rapid absorption and allow the feces to be liquid.

The case reported by Dr. Skinner is an exceedingly instructive one, and one which comes up every now and then in practice. The doctor has said very properly that it is a most puzzling case to present. For some reason we always think the worst about our patients; we are apt to think of appendicitis, then of colic, then of intussusception, etc., and in this case there seems to have been about this line of symptoms, yet it was evidently a case of torpidity of the bowels with no great accumulation of fecal matter.

Referring to Dr. Skinner's statement that many of these cases take sufficient exercise, this is not in accord with my observations of chronic constipation. I believe that the cecum is so constructed, whether it is the design of nature to do this or not, that walking exercise has an effect like rubbing the cecum, on account of the muscles which pass behind it. The cecum is moved when a person is walking, which is not the case by any other means, except possibly riding a bicycle, and this point I understand is to be brought out later in this Society, as a committee has been appointed to make some investigations in that direction.

Now, as to medicinal agents. We all know that purgatives given *per se* are injurious to a case of this kind. They call upon the peristaltic action of the bowels, and every time this is called upon the natural power of the peristalsis in the bowel is lessened. Consequently the more purgatives a patient takes the more he must take, and all of them after a while lose their effect. In those cases where medication becomes necessary, I believe it is far more sensible to administer an agent which shall paralyze the inhibitory nervous supply and stimulate the sympathetic nervous supply. For this purpose I do not think there is any thing equal to belladonna and strychnine. The "little pill" of belladonna, aloine, and strychnine I believe to be the best known combination. These are agents which do the work of paralyzing, and I believe in these cases if morphine and atropine were given hypodermatically

you would have the desired effect without calomel. The check on the pneumogastric nerve as it is distributed to the bowel is lessened by belladonna; it paralyzes that nerve, allowing the feces to become free. I do not think we have in the list of medicines an agent which will do the work that belladonna does in this particular; not belladonna alone, but all its congeneric mydriatics—and all the mydriatics act in the same way if we add to them strychnine, which possesses in itself a tonicity for the bowels.

I have seen several cases of chronic constipation in infants. In these cases I have found that rubbing or kneading the bowels with the hands for five or ten minutes produces an alvine dejection. We want, of course, to increase the tone of the bowels, but I would urge the use of simply large quantities of water, as this alone will usually produce catharsis.

Dr. D. T. Smith: The subject up for discussion, as stated by the previous speaker, is regarded as one of special importance. Dr. Skinner has narrowed the discussion very much by limiting it to functional constipation. The case reported by him may or may not have an application as illustrating a principle; I rather think it has not. It may be more reasonable to suppose that there is an adhesion at some point in the colon in the case of his patient, and the peristalsis arising at that point after narrowing might be sufficient to cause that condition. We very frequently find that. However, we do not observe vomiting in cases of functional obstruction. There is sometimes paralysis or peritonitis of that small portion of the intestine which might be sufficient to cause death. I think, from the history, that the trouble is simply an adhesion causing a narrowing of the intestine or an arrest of peristalsis at some point.

Concerning the treatment of constipation: As this is a condition which is usually suspected to arise from an accumulation or obstruction of material that ought to have passed out with the fecal discharges, the most important thing is to relieve the patient of this obstruction, and then administer remedies which are known to have a stimulating effect upon the bowels.

I reported before this Society some time ago a case which Dr. Roberts saw with me, in which preparations were not exactly made, nevertheless every thing was gotten in readiness to do an exploratory laparotomy for the relief of constipation. There was stercoraceous vomiting and other symptoms of obstruction. However, before the time to

operate, we gave a pint of sweet oil, knowing it to be a safe remedy in any attack, and the result was an almost immediate disappearance of the distressing symptoms; the patient recovered and is in fine health to-day. In this case there was retroversion of the uterus, some post-pelvic peritonitis, and evidence of adhesions, which probably accounted for the trouble.

As Dr. Larrabee has said, the two remedies most relied upon in the treatment of constipation, as they do not irritate, are belladonna and strychnine, because they stimulate the muscular coat of the bowel, and by stimulating its action develop a strength that overcomes the atonic condition. As far back as 1861 I know that belladonna, nux vomica, and compound extract of colocynth were given in this way. Aloes act as a stimulant in a similar way.

In regard to the use of water, there are two respects in which water will be beneficial. In the morning, when we rise (with those of us who are subject to an accumulation of mucus in the lungs and stomach), the whole alimentary canal is covered with mucus accumulated during the night, and water taken early and freely will reach the lower bowel without being absorbed. Ordinarily there is an abundance of water passing into the blood and then back into the large bowel, because we know a considerable number of substances are carried into the circulation and then back again through the large intestine, not reaching the small intestine. Therefore about the only way to have water freely reach the small intestine unabsorbed is by taking it in the early morning. I find many patients unable to take more than one glassful immediately on rising owing to the nausea produced, and it becomes necessary for them to wait for a few minutes until this feeling passes off before taking the second glass. I direct them to take three or four glasses, if they find it necessary, or if less fails to do the work, until a sufficient quantity of water is taken before breakfast to secure an action of the bowels shortly afterward. One of the most important things in this connection is that we should have a certain time for evacuation each day. The absence of a fixed period for an effort at stool may be the cause of the trouble in many of these cases. Any person not giving the bowels opportunity to act at a given time will necessarily become constipated, even if the alimentary canal is in a healthy condition; then I think it is not a bad plan for a while to induce excessive or overaction.

I believe, if proper attention were given to the matter of having a regular period for evacuation of the bowels, and patients instructed to

drink water in the early morning and a sufficient amount later in the day, that the administration of cathartics could be done away with to a great extent. I am aware, while I am saying this, that there are many people who can not drink water, cases of gouty diathesis, etc., and for this class of people salines can be given which will carry the water through the stomach, which otherwise could not be done.

Dr. Wilson: I have been in the habit of using hot as well as cold water. Hot water is not quite as pleasant perhaps, but with the addition of a little lemon juice or salt it becomes really palatable, and patients get very fond of it. I believe hot water preferable to cold, as it reduces the supply of blood in the capillaries of the walls of the stomach, which thus warmed up is driven directly through the liver, through the pancreas and neighboring organs, stimulating them to increased activity, and we have necessarily an increased supply of bile. On the other hand it increases the digestive fluid supply, not only in the stomach itself but in the pancreas, so that digestion is improved, and at the same time peristaltic action is stimulated.

Dr. J. G. Cecil: I have listened with a great deal of interest to the excellent paper read by Dr. Skinner, and to those who have already spoken. I fully agree that the subject of constipation can not be too freely discussed, as it is a matter of very considerable importance. If I am a routinist in any thing, it is in giving purgatives, and I very seldom undertake the treatment of a case of any kind without very carefully inquiring into the condition of the bowels, and generally find that a purgative is demanded, and usually also find that all medicines, as Dr. Larrabee has very properly said, are increased in their efficiency by having the alimentary canal cleared out before their administration. I have for a long time been very much of the same opinion as the essayist with regard to the administration of water, and have often recommended it. I believe that the beneficial effects derived from many of the mineral springs, which are visited owing to their advertised efficiency for constipation, depend largely, perhaps, upon the water taken because it is water and not so much from the fact that it contains medicinal properties; quite as much also upon the quantity and regularity with which it is taken.

Concerning the point raised by Dr. Larrabee in regard to constipation in infants: This is a matter that has caused me a great deal of trouble in my practice. Very frequently infants nursing or feeding upon the bottle become obstinately constipated, and I have recently

been in the habit of advising that the children be given water. I think this is a point that is often overlooked in the treatment of children, the mother or nurse naturally assuming that the infant gets sufficient quantity of water in the milk. I believe constipation in many of them is very agreeably affected and frequently cured by the administration of water.

The case reported by Dr. Skinner is one of extreme interest; the history shows that this woman was nearing a point where surgical interference was urgently demanded. However, the first visit I made, having seen the patient after she had been constipated several days, and after large quantities of purgative medicines had been given, after she had had injections also, and with the history of the case given before I saw her, I was led to suspect a very different condition from what I really found. The patient was in a fairly good condition, not particularly anxious in expression, not restless, not tympanitic, no fever, no tenderness, fairly good pulse, and thoroughly rational, and under the most careful examination I was unable to locate any tender spot or tumor in the abdominal cavity or any accumulation of fecal matter. The hernia, or whatever it was in the inguinal region, to my mind had no bearing upon the case. I think, if there had been an adhesion or stricture of the bowel at any point, as hinted by Dr. Smith, we would have had a different line of symptoms from those present. I would hardly have expected to have seen an amelioration of symptoms without perfect relief, and I would have certainly expected to find an accumulation of fecal matter above this constriction, which we could not locate. I do not think I remember to have ever seen a case that resisted such heroic doses of purgative medicines as this woman did. Probably a week after my first visit Dr. Skinner met me on the street and told me that she was still constipated; he had tried injections or flushing the bowels (Dr. Mathews' suggestion), which I am sure was followed out with a thoroughness not often practiced, as Dr. Skinner did the work himself, and had there been simply an ordinary constipation of the lower bowel I am satisfied this treatment would have solved the problem. But, as already indicated, there was no effect. She was benefited by the amount of water used in these injections, as I understand several were retained. To my mind there is no cause assignable for the obstinate constipation in this case other than torpidity of the liver and bowels. Possibly there might have been temporary paresis of the small bowel; the constipation, I am satisfied, was in the small bowel.

Dr. T. S. Bullock: I only want to speak of the manner in which the flushing was done in this case. It was done through a rectal tube passed to the sigmoid flexure, a copious amount of fluid being used as already indicated, and if there had been an accumulation of fecal matter in the larger bowel I am inclined to think that it would have been very promptly removed by these repeated large amounts of water. Only a very small quantity of hard fecal matter was brought away by the injections.

Dr. W. Carroll Chapman (visiting): I would like to mention one point in this connection, which seems to me to come under the head of functional causes of constipation, especially in women, and that is lack of effort, which is often due, I find, to pain, due to congestion and the attending sensitiveness in the genital organs—the ovaries, uterus, or vagina. I have often seen women who were not really constipated so far as desire goes, but complained that when they wanted to have stools they could do so, excepting the effort caused them so much pain that they would not make sufficient effort to produce an evacuation. It seems to me where this is the case, and I am satisfied that in women it does occur frequently, we should by hot injections or special applications, as may seem best, endeavor to relieve this condition, which would doubtless relieve or possibly entirely cure the constipation.

Dr. Larrabee: The element of colic has been alluded to, which was entirely overlooked by me in my former remarks concerning Dr. Skinner's case. How are we to determine that it was colic? One feature or one kind of constipation that ought to be alluded to is that not caused by paralysis, but by constriction. For example, take a case of lead colic, if you please, a case in which you have a portion of the intestine ligated by a circle of fibrous material with extreme pain. What kind of a purgative would you give there? Certainly any effort to increase the peristaltic action would increase the trouble. Under these circumstances I believe that large doses of opium will produce an action from the bowels, an agent which it is well known will produce constipation. But under these conditions an action is produced upon purely scientific principles; it paralyzes the circular fibers. Whenever I see a case of lead colic, and obtain that history (I usually find that the patient has already taken large quantities of purgative medicine without effect), I administer large doses of opium, and it has been my experience that relief follows. Instead of paresis we can have an opposite condition of constriction by the circular fibers.

Dr. Smith: I intended in my former remarks to refer to Dr. Larrabee's statement as to the way in which belladonna affects the bowel. I believe that the doctor claimed that the good effects of this drug were produced by removing inhibition. I have never heard of any teaching that belladonna acts in this way. There are no ganglia situated in the walls of the intestines stimulating their action as there are in the heart. Belladonna, we know, acts doubly on the heart; acts directly upon the heart muscles, at least acts by inhibition of the motor centers from its own ganglia. I believe that the increased peristalsis is due to direct paralysis not to an inhibitory one, as the doctor claims.

Dr. Larrabee: All experiments upon the subject of belladonna, which have been conducted by vivisection and otherwise, have shown that this above all other drugs places the intestines in peristaltic action. Wherever there is a branch of the inhibitory nerve belladonna acts, no matter whether by the capillaries, heart, liver or otherwise; wherever inhibition goes there stimulation goes, and both go to every part of the economy. Every action of the body is controlled by two forces, like driving a horse with two reins; between the two you get a rhythmical action, but when one or the other is crossed a different result is obtained. Of course the effect of belladonna is through its action on the pneumogastric nerve. The benefit is derived by taking off the power of checking.

Dr. C. Skinner: Concerning the administration of morphine in the case referred to in the paper, we all thought after it had been given that we ought not to have left the hypodermic injection there. If I had left the atropia without the morphine, I think it would have been better, as the morphia was undoubtedly the cause of the masked symptoms the second day. I believe it is a great mistake to give a hypodermatic of morphine when you want to make a differential diagnosis in such cases.

As to constipation in infants: Water can be administered in these cases with good results, just as with adults. Mothers and nurses all tell you that the baby will not take water. That may be true, but the reason is that they have never been taught to take it. After a little perseverance on the part of nurses the baby will of course take a sufficient amount of water to obtain the desired result.

As to massage, that was not mentioned in the paper; I referred simply to the water treatment.

I agree with Dr. Smith, that having a stated time for evacuation of

the bowels is an important factor. There is one thing above all others that a physician will observe in the treatment of constipation, and that is the little attention that these people give to periodical movements of the bowels. One reason why it is so common in women is, that, from a false modesty or other reasons, they do not attend to this call of nature as they should. In this way constipation is started, and then it keeps itself up.

Referring to Dr. Wilson's remarks in regard to his preference for hot water, I use cold water because I think patients will take more of it, and it is easier to take. In this special class of cases, where we have young women from fifteen to thirty years of age to deal with, they will not take hot water. In older people probably hot water is more preferable.

Dr. Chapman mentioned one very important thing in reference to constipation in women, that is pain produced by any effort at stool; for instance, a displaced ovary may render defecation very painful, especially if the feces have become hard; the pressure upon the prolapsed ovary will produce such pain that the patient is unable to make the necessary effort at stool. The majority of these cases are usually controlled by divulsion; you can take a case of this character and dilate the sphincter, after a short time relief will usually follow.

Dr. Bullock spoke of the injections in the case reported by me. I know that these injections were very carefully given, and were really irrigations. I used a No. 7 tube its full length. In the first or second injection probably an ounce of fecal matter came away; after this nothing was returned except the injected water; for that reason we believed that the trouble was not in the large intestine, but a torpid small bowel.

J. E. HAYS, M. D., *Secretary.*

THE TREATMENT OF HEMOPTYSIS.—M. Comby recommends repose, such revulsives as dry cups, sinapisms, poultices of mustard and flaxseed, dry frictions, or with alcohol or the turpentine. For internal medication a pill of ergot, digitalis, and quinine, or ergotine in gooseberry syrup. Direct astringents may be found in subacetate of lead, or rhatany, or perchloride of iron by atomization. Acid draughts, as the sulphuric-acid lemonade, are serviceable. The balsams have some reputation, and a combination of benzoin and alum in aqueous solution is of good repute. Opium has great value but chiefly through its calmative effects.—*La Médecine Moderne*, 1892.

Reviews and Bibliography.

A System of Genito-Urinary Diseases, Syphilology and Dermatology. By various authors. Edited by PRINCE A. MORROW, A. M., M. D. With illustrations. In three volumes. Vol. 1. Genito-Urinary Diseases. 1074 pp. New York: D. Appleton and Company. 1893.

Following the practice that has recently been gaining vogue so rapidly, the editor has sought to obtain a complete treatise on the three associated departments of general medicine and surgery embraced in the present "system" by enlisting the co-operation of a large number of distinguished specialists. Each of these has been selected for his special fitness to write on the subject assigned, and, as far as practicable, has been given the subject of his choice.

The result has been a thoroughly practical treatise, and one well adapted to the wants of the general practitioner as well as the specialist.

It is gratifying to see the steady growth of the scientific method in the study of disease and its treatment that characterizes this as well as most other recent contributions to medical literature.

The dawn is melting into the sunlight, and now we can begin to look back into the murky mist that hangs over much of the medicine of the past, as in the mind's eye we may look upon the clouds that in early geologic periods hung over the earth's surface. Surgery outtravels medicine, but both are making rapid strides.

Passing over the first chapters, which are mainly surgical, attention is arrested by the subject of gonorrhea, this being one with the treatment of which every one has had experience. One might in the first place be surprised at the uncertain tenure by which the gonococcus has come to hold its place, if it were not that similar recasting of views has been recently going on throughout the domain of bacteriology. But what of the treatment? The author, Dr. Brewer, condemns the expectant plan of treatment advocated by Fournier, but he himself condemns all internal medicines as useless except for comfort. Local treatment he holds in greater favor. Astringents in the declining stage he regards as highly helpful. But to corrosive sublimate he awards the palm. It is to be feared, however, that the gonococcus, in view of the recent damaging attacks made on the bichloride and the desertion of its friends, will in a short time become much more refractory than the author has found in the presence of that drug.

After all we should not be surprised if the time should come when the frequent removal of the pus with warm water, containing enough salines to prevent the maceration of the urethral tissues, should be settled upon as the best local treatment to be obtained. We know how destructive decomposing pus can be when held in contact with the eye and with ulcers. It

would seem to be the removal of this that is the one thing imperative in the treatment of gonorrhea.

The chapter on stricture also discloses a shifting from views of treatment held only a little while since as positively as if a finality had been reached.

Altogether Dr. Morrow and his coadjutors have done their work well, and have given the profession a volume that patients everywhere, if they but knew what was here done for them, would be grateful for. D. T. S.

Alcoholism and its Treatment. By J. E. USHER, M. D., Fellow of the Royal Geographical Society of London. 151 pp. New York: G. P. Putnam's Sons. London: Bailliere, Tindell & Cox. 1892.

This is a more than usually well-written and philosophical work of its class, being free from much of the extravagance of most works of the kind given on this side of the water. It is not easy indeed to find a production with us in opposition to the use of alcohol that is not so colored by partisan bias as to necessitate a large discount for the personal equation. In the work before us most of the reasonings are fair, and little objection can be made to the author's conclusions. It may be questioned, however, whether the habit of using alcohol to excess really entails the alcohol neuroses on the children of those so using it, as the author would imply. The drink-craze does not seem to be so easily installed in the category of inherited tendencies. The sons of drunkards drink, it is true, but why did the drunkards drink? Tradition does not tell when the Indians indulged the use of alcohol, yet they are a race of drunkards. One might as reasonably conclude that drunkenness ultimately makes a sober race by eliminating the families that have the diathesis that provokes to inebriety.

For treatment the author pursues the course approved in large measure by Norman, Kerr, Mattison, and others. The Keeley cure he condemns, and there can be little doubt that the beneficent craze produced by the dramatic methods, and sustained by the strong personality of the originator will soon pass away, and that it will be shown that the medical means have little in them that is different from what many others have employed. The author goes somewhat extensively into the medico-legal aspect of inebriety, but he does not do this so well nor so fully as is done in the latest edition of Taylor's Medical Jurisprudence. D. T. S.

Hand-book of Insanity for Practitioners and Students. By THEODORE KIRCHOFF, Physician to the Schleswig Insane Asylum, and Privat-docent at the University of Kiel. Illustrated with eleven plates. 362 pp. New York: William Wood & Co. 1893.

This hand-book, besides being highly instructive, is one of the most entertaining works in the literature of insanity.

More than has been the custom with previous writers the author insists on the presence of an anatomical lesion as the basis of insanity in all cases, although he does not pretend that such lesion is invariably discoverable.

The work is remarkable for the profusion with which symptoms are given as found in different forms of insanity, conveying thus a somewhat adequate notion of the almost infinite variety of phases of the disease. The nomenclature is something of a departure, and in some respects markedly different from that of most authors. Thus, instead of making melancholia a chronic mania, he would make melancholia and mania separate forms. Where the emotions are not involved, and where the delusions are not fixed and organized, he would denominate the disease melancholia. Mania applies to cases in which the delusions are not organized and where emotional disturbances are present.

When the delusions are systematized he would denominate the disease paranoia. Paranoia is subdivided into "*wahnsinn*" and "*verruecktheit*." *Wahnsinn* embraces cases of emotional character, while *verruecktheit* embraces cases in which the emotions are not involved. These terms find their correspondents in the old divisions of ideational and emotional insanity, and while verbally making the subject more plain in their practical application leave the student not greatly better off than before. As the author acknowledges, the subject of insanity is infinitely complex, and a definite and clearly distinguishing nomenclature is beyond the range of hope. That which is attainable, however, and devoutly to be wished, is that neurologists in all countries will settle on a uniform nomenclature, even though it be not accurately descriptive.

D. T. S.

Modern Gynecology : A Treatise on Diseases of Women, comprising the Results of the Latest Investigations and Treatment in this Branch of Medical Science. By CHARLES H. BUSHONG, M.D., Assistant Gynecologist to the Demilt Dispensary, New York, etc. Illustrated. 380 pp. Price \$2.75. New York: E. B. Treat. 1893.

This work is intended to meet the wants of the family physician, and enable him to treat such cases as fall into his hands and do not require the intervention of the surgeon. The book is quite opportune, for it draws attention to a vast number of ailments that are too apt to be overlooked, overshadowed as they have lately come to be by the smaller number of female afflictions that invoke for their treatment the more brilliant displays of surgery. The treatment recommended by the author commends itself, in nearly every case, to common sense and experience. In a few instances many would doubtless take issue with the author. The reviewer has found so many uses for the persulphate of iron that he has had occasion to fear that he might be regarded as a hobbyist in its employment. But among all the applications of it for which occasion has been found, it has not once occurred that the application of this salt to the vault of the vagina might promote the absorption of cicatricial tissue in the adnexes of the uterus or benefit fibroids in its walls or cavity. There are many recent works on gynecology, a large part of them serving no other purpose than to advertise their authors; but this work, though unpretentious, will, we believe, prove of great practical value and a real boon to large numbers of suffering women.

D. T. S.

Foreign Correspondence.

LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

Death of Professor Macnamara; The Brompton Hospital Entertainments; Traumatic Rupture of Spleen; A Royal Surgeon; A Castor Oil Story; An Antidote for Cyanide of Potassium; The Cholera Conference; The North London Hospital; Chemists' and Druggists' Exhibition.

The death of Professor Rawdon Macnamara, of Dublin, from acute pneumonia removes a most popular member of the profession. Professor Macnamara represented the Royal College of Surgeons of Ireland on the General Medical Council, and was one of the surgeons of the Meath Hospital.

During the month the many entertainments given at the Brompton Hospital in the cause of the suffering inmates was brought to a close. For twenty-six consecutive seasons have friends of this well known charity, by the magic of song and mirth, temporarily banished dull care from the inmates, and not a week has passed since November that artists have not been found to give their time and talent for the alleviation of illness and pain. There are at present almost three hundred occupants of the wards, and as many of these as could leave their beds assembled in the fine pillared room especially set apart in the extension building for dramatic and musical entertainments.

At the last meeting of the Clinical Society an interesting case of traumatic rupture of the spleen was described. It appears that a man aged forty, having fallen fifteen feet, walked to the hospital without assistance. Three hours after the accident he was found to be suffering from moderate shock and pain near the tenth left rib. The following day there were evidences of fluid in the peritoneum, along with signs of internal hemorrhage. Four pints of saline solution were infused. Upon laparotomy being performed, seventy-five ounces of blood were removed from the abdominal cavity. The spleen was found to be torn, and the injured vessels were secured with silk, the ends of the ligatures being cut off short. The peritoneum having been irrigated, the opening was closed round a glass tube. Five more pints of saline infusion were then injected. The patient went on well for forty-eight hours, localized peritonitis then setting in. The man died on the sixth day. Dr. Battle thought that the use of saline infusion, combined with surgical means to prevent hemorrhage, might be expected to save an otherwise hopeless case. He laid great stress on the necessity for frequent abdominal examinations after injury, in order to discover the

earliest signs of the presence of blood in the peritoneal cavity. Rupture of a normal spleen produced a train of symptoms resembling those caused by a wounded artery, the quantity of blood poured out varying with the extent of the wound. The large majority of cases were rapidly fatal, but should a patient survive sufficiently long for laparotomy to be performed, and bleeding was found to be still going on, the spleen should be excised.

His Royal Highness the Duke Charles Theodore, of Bavaria, elder brother of the Empress of Austria, and head of the ducal branch of the Bavarian royal family, has just performed his two thousandth operation for cataract.

The Royal General Dispensary near St. Bartholomew's Hospital is one of the oldest institutions of its kind, and is successfully carried on for the benefit of the poor. Here a small charge is made for the medicine supplied to meet the actual cost, and this charge is said to have come about in a curious way. Years ago there was no charge either for advice or medicine, and it was found that there was an astonishing run of castor oil. This was explained at last. It appears that many of the patients were seamstresses, and the castor oil was used as a lubricant of the sewing machines. The plan of charging a small fee was then introduced, and has been in operation ever since.

As the result of some experiments on guinea-pigs, it is found that permanganate of potash in solution of the strength of one third to one half per cent is a perfect antidote to cyanide of potassium, which it transforms into cyanate of potash, a substance comparatively innocuous. It is thought that a solution of the above strength may be drunk, in cases of poisoning, at the dose of a pint.

The convention signed by five out of the six European powers represented at the Dresden International Conference on Cholera adopts in the main the proposals of the British delegates. The convention has not yet been signed on behalf of Great Britain, but this formality will, it is stated, be undertaken during the next few days by Lord Roseberry. The convention sets forth that every Government signatory thereto is bound to communicate with every other Government official information concerning any outbreak of cholera which may occur in its territory, and to indicate the exact place affected and the extent of the disease. No country is to take any measures against another, and must only deal with its own actual locality affected. There is to be no prohibition against any article being imported or exported except that which can be shown capable of conveying the disease.

Speaking at the festival dinner of the North London Hospital for Consumption, the president said that no conditions of human life could be more favorable to the promotion of the dread disease than that of the close, confined London alleys and the fetid atmosphere of the streets. The hospitals prevented London becoming the abomination of desolation. They contained 8,500 beds, of which 6,500 were continually occupied. The great

German master who was here recently thought that specialism might be injured by dissociation from other branches. From going over the North London Hospital the president was himself perfectly satisfied as to its management and work. They had hoped that some important advance would be made in the treatment of pulmonary diseases; but while pathologists might be on the eve of a great discovery, specialists seemed to believe that Dr. Koch was on the right path. He looked forward to the time when hospitals for dealing with chest diseases would have sanitariums in better climates. The fact was also mentioned, that Baron Nathaniel de Rothschild had given his castle at Beichenau at the foot of the Semmering, with the extensive grounds belonging to it, to a society which is founding a hospital for consumptives. The castle has been built within the last ten years, and is roomy enough to contain four hundred patients, is in a beautifully sheltered spot, and the gardens are filled with the finest roses in the whole neighborhood. The castle which Baron Rothschild had so generously given away is worth several million florins.

How much the public owe to, and how wonderful is the modern pharmacopeia, has been demonstrated by the Chemists' and Druggists' Exhibition which has been held for six days at the Royal Agricultural Hall. The object of the display was to show to the public and the trade the extent and variety of the modes for saving life by medicine, and further to illustrate that science and the art of healing are marching hand in hand. It is stated that the Exhibition, which has been an undoubted success, is to become annual.

A work-house porter at Lymington has been sentenced to twelve months' hard labor for causing the death of a lad by pouring carbolic acid upon him while he was taking the admission bath.

LONDON, April, 1893.

ABSCCESS OF THE PANCREAS.—Dr. Whitton describes the case of a man who had fallen from his dray in a state of intoxication, and was admitted to hospital with four ribs broken. Next day there was some tympanites, and he was coughing a good deal. The third day he began to vomit a bilious fluid, and complained of a fixed pain just above the umbilicus. For a week the patient's condition fluctuated, the vomiting and pain being the chief symptoms, though neither of them was constant. At the end of this time he seemed worse. There was some diarrhea, when at 3 P. M. he began to vomit yellowish fetid pus, and gradually sank, dying at eight o'clock the same day. At the *post-mortem* some recent pleuritic adhesions were found on the right side in the neighborhood of the fractured ribs, and the liver was friable; but the chief result was the discovery of an abscess in the pancreas, penetrating the duodenum about eight inches from the pyloric end of the stomach.—*Australian Medical Gazette*.

Abstracts and Selections.

DIRECT APPLICATION OF MENTHOL TO THE STOMACH.—A. L. Benedict (Inter. Med. Mag., November) speaks well of the effect of a menthol spray applied directly to the mucous membrane of the stomach in cases of atony or catarrh of that organ. The method of procedure is as follows: The patient should be directed to take no food within four hours of the application, and the last meal should be a light one. Lavage is carried out in the ordinary way, plain water or a weak alkaline solution of about the body temperature being used, and the washing being repeated until the fluid returns free from shreds of mucus. A one to five-per-cent oily solution of menthol should then be sprayed into the stomach through the tube; an ordinary nickel tube perfume atomizer serves the purpose perfectly well. The spray may be directed into the funnel, or the latter may be removed, and the tip of the atomizer introduced into the tube. The vapor, like the fluid previously used, should have an alternate ingress and egress; by pinching the tube close around the tip of the atomizer the stomach may be fully distended, and it should then be allowed to contract upon its gaseous contents, when the vapor and even drops of water will be expelled with considerable force from the mouth of the tube. The patient almost always states that he perceives the taste of peppermint in his mouth. The vapor should be introduced into the stomach, and that organ allowed to contract upon it six or seven times, so as to insure the remedy coming in contact with the whole internal surface of the viscus. Details of several cases in which this method was used with great advantage are given, and the author suggests that other medicinal agents, such as nitrate of silver, might be applied to the internal surface of the stomach in the same way in cases of gastric ulcer, etc.—*British Medical Journal*.

CANCER.—A society has recently been formed at Paris called *La Ligue contre le Cancer*, the objects of which are the study of cancer, its history, pathology, and the best means for preventing its spread therapeutically and otherwise. The membership consists of *benefactors*, contributing pecuniarily to the work of the society; *founders*, who subscribe three hundred francs each; *honorary members*, contributing original or other scientific material to the study of cancer; *members*, paying twenty francs yearly; *life members*, paying two hundred francs in one sum. The society will publish a quarterly bulletin. Its officers are as follows: Verneuil, Honorary President; Duplay, President; Reclus, Secretary; Ricard, Secretary of Surgical Section; Brault, Secretary of Medical Section; Cazin, Secretary of Pathological Section; G. Masson, Treasurer, 120 Boulevard St. Germain, Paris.—*Boston Medical and Surgical Journal*.

THE AMERICAN PRACTITIONER AND NEWS.

"*NEC TENUI PENNÂ.*"

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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ASEPSIS THAT IS NOT ASEPSIS.

After all that has been said and written upon the subject of asepsis and antisepsis it is strange to note how few physicians and surgeons are awake to what is really meant by the terms.

The germs of disease may and do cling to almost any object in the operating-room, and for the aseptic surgeon to touch any thing except the area to be operated upon, and the disinfected instruments and apparatus needed for the work, is, of course, setting at naught the very principle upon which asepsis depends, while results not infrequently give gruesome emphasis to the transgression.

It has seldom been our lot to witness a surgical operation wherein all the necessary precautions against outside contamination had been taken. There was somewhere a break in the chain; a break that might under some circumstances defeat the ends of the operation.

If this be true of surgeons in the performance of major operations, it is more strikingly true of physicians and obstetricians in the doing of minor operations, and in the surgery of the lying-in room. How many a cut is sutured with needles and thread taken from the unsanitary pocket-case of the doctor whose instruments were never treated to boiling water or other antiseptic bath! How many obstetric forceps are allowed to lie upon the dusty carpet or dirty bed-clothes after being taken from the boiling water, and then applied! How many a catheter is pushed into the victim's bladder without having been passed through an

antiseptic wash, or after having been so treated has had its perviousness tested by the germ-laden breath of the accoucheur! How much dirty lard, goose-grease, and cotton-seed oil, have lubricated the unwashed hands of the doctor who waits on woman in her sorest need!

Some of these are gross sins of negligence which the conscientious doctor will not commit, whether he pin his faith to the doctrine of disease produced by germs or not. But there are minor sins of commission and omission of which all are guilty through a failure to fully understand or religiously carry out what is meant by aseptic surgery and midwifery.

A striking instance of this is in the following, which we clip from the New York Medical Journal of the 13th ult.:

A LESSON IN ANTISEPSIS.—The scene occurred in one of the most prominent of our New York hospitals, the time of action was within the last five years, and the *dramatis personæ* were a patient who was to have a portion of his cerebral cortex removed, one of the best of New York surgeons, a prominent neurologist, assistants, visitors, and students. The surgeon had deftly and carefully removed the bone and made a flap in the meninges, and the neurologist was about to decide the location of the cortical center. Turning on the current of his battery, he applied the electrodes to his tongue to determine the strength of the current, and was about to transfer the electrodes to the cortex when the surgeon, who had watched this method of current-testing with evident concern, arrested the neurologist's hand, saying at the same time that the electrodes must be disinfected again after contact with his mouth. The disinfection of the instrument being completed, the neurologist confirmed the location of the center, and the surgeon prepared to complete his work. As he took his stool to resume the use of the knife he found that the light was insufficient; rising, he caught hold of the gas fixture placed above the operating-table, pulled it down over the field of work, placed his stool in a little more convenient position, and, forgetting to disinfect his hands, proceeded with the operation. The mote caused by the neurologist's *gaucherie* had been removed, but the beam of the surgeon's forgetfulness resulted in the death of the patient in consequence of suppurative meningitis.

WOMEN AND THE HARVARD MEDICAL SCHOOL.—The Faculty of the Harvard Medical School at their last meeting voted, by a majority of twelve to nine, not to ask the corporation of the University for authority to admit women to graduate courses if at any time or in particular cases it should wish to do so.—*Boston Medical and Surgical Journal*.

Notes and Queries.

THE PROOF OF DEATH.—The minds of some persons are haunted by a persistent fear lest their bodies should be buried alive, a fear which is happily almost destitute of any rational excuse. The aspect of death is in every way so different from that of life that it needs no skilled inspection to distinguish it. This is the rule, and one broken but very rarely by an exception. Occasionally, however, some difficulty has arisen even as regards this primary distinction. A case recently reported may be mentioned in illustration. A newly-born infant of poor vitality, whose mother died in her confinement, had, after a short time, apparently died also, and was actually coffined when a cry revealed the fact that it still breathed. Later, on the same day, the vital flicker again appeared to be extinguished, but this time the care of the medical attendant prevented the occurrence of any mistake as to its existence. It has been suggested that in order to guard against the possibility of any such disastrous oversight in future no certificate of death shall be given except after personal inspection of the deceased by a medical man. We do not know of any objection to this proposal. On the contrary it has much to recommend it. The ordinary signs of death do not require any full explanation on our part. It is worth while to note, however, that such a case as that referred to above is exactly of the kind in which especial care should be exercised as regards this matter. It is where extreme feebleness results in a state of torpor continuing perhaps for days with faint signs of life, where breath and heart-beat show but an occasional indication, where the muscular power is nearly absent, as in old paralytics, and *rigor mortis* hardly to be depended on, that we seek with some anxiety for absolute proof of death. This is to be looked for in such cases, not so much in any isolated sign as in the association of several to the exclusion of all vital manifestations. Among the most reliable indications that life is extinct we would mention rigidity, cadaveric discolorations in relation to position and surface pressure, and as an early and almost certain sign the glary eyeball, with its pupillary aperture fixed in dilatation.—*London Lancet*.

A LONG TERM OF STUDY.—The Boston Medical and Surgical Journal thus closes its editorial comment upon the Dean's report of the Harvard College:

Dr. J. S. Billings, in a recent article on Medicine as a Career, arranges the preparatory years of one who would fit himself for the medical life, as follows: "My young friend, whose attention I wish to direct to medicine as a career, will have spent five years at a good intermediate school as a pre-

liminary to entering the university, which he does when he is about seventeen years old. He spent three or four years at the university, four years at the medical school, one and one half years in the hospital, and two years in travel and special studies. When, therefore, he is ready to begin work he will be about twenty-eight years old, and his education, living, books, etc., will have cost about eight thousand dollars from the time he entered the university. It can be done for less, but this is a fair average estimate."

If this imaginary young friend went to Harvard, he would be more nearly nineteen than seventeen on entering the undergraduate department; he would be about twenty-three on entering the medical school with an A. B. degree; he would be twenty-seven when he secured his M. D. degree; and if he spent eighteen months in a hospital and two years in travel and special studies, he would be fully thirty years of age when ready to begin the practice of an arduous profession, the first years of which are apt to be years of patient drudgery. For turning such years to profitable account, the hopefulness, the enthusiasm, the elasticity of youth are most essential. But at the age of thirty for most men the sun is already high above the horizon, the dew is off the grass, and the first freshness has gone from the morning air.

Dr. Billings' programme is a little too elaborate for the average medical aspirant, for whom it is hardly meant; but if this is true, in a still greater degree is it true that the double Harvard degrees (A. B. and M. D.) with their present requirements are luxuries suited for a small number of exceptionally placed men.

LEMONADE AS A VEHICLE FOR CHLORAL.—Dr. E. Holland calls attention to the fact that the taste of chloral hydrate is effectively masked by lemonade. Two or three drams of the syrup should be placed in a tumbler with about two ounces of water. If to this is added about two ounces or so of gaseous (bottled) lemonade, the mixture may be drunk at leisure, and the soporific action of the drug is in no way impaired.—*London Practitioner*.

Special Notices.

Notwithstanding the large number of HYPOPHOSPHITES on the market, it is quite difficult to obtain a uniform and reliable Syrup. "ROBINSON'S" is a highly elegant preparation, and possesses an advantage over some others, in that it holds the various salts, including Iron, Quinine, and Strychnine, etc., in PERFECT SOLUTION, and is not liable to the formation of fungous growths.

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| Glycerine, | 1 ½ oz. ; |
| Port Wine, | 2 oz. ; |
| Hydrastia sulph, | 4 gr. ; |
| Aquæ destil., | 2 oz. |

THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNÂ."

VOL. XV.

LOUISVILLE, KY., JUNE 17, 1893.

NO. 12.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

REPORT ON RECTAL DISEASES.*

BY W. O. GREEN, M. D.

Fellow of the British Gynecological Society, Member of the Kentucky State Medical Society, Consulting Rectal Surgeon to the Louisville City Hospital, etc.

The following report on rectal diseases is respectfully submitted for your consideration. Its object is to call your attention, as briefly as is consistent, to the most practicable and important matter that has appeared since your last meeting, and occasionally add such other material as necessity demands.

Excision of the Rectum. If we are to judge from the number of articles that have appeared in the medical press during the past year, no department of rectal surgery has received so much attention as the subject of excision for cancer. Several reasons, such as the brilliancy of the operation, the arrival of the time, and its immanent necessity, have been assigned, but its present impulse seems in a great measure due to the divergence of opinions regarding colotomy. The pro-colotomists, through their most creditable researches and able discussions, have contributed much valuable information upon this surgical procedure, while the anti-colotomists can justly claim a very deserving share of the honor for drawing the lines of its indications more distinctly. Be this as it may, what concerns us most is the present status of affairs.

It seems now very generally conceded that when a cancer of the rectum is diagnosed, the operative treatment that offers the most satis-

*Read at the May meeting of the Kentucky State Medical Society, 1893.

factory results resolves itself into two procedures, colotomy and excision. It should not be understood by this that other methods have been abandoned, or yet greatly neglected; but, in case a decision is to be made by the surgeon himself, colotomy or excision should always demand his first consideration, and the sooner the better.

It must not be forgotten, however, that the operation of excision for carcinomatous disease has a very limited field of usefulness. The full extent of this has not yet been clearly marked out, but in well-selected cases much good can be accomplished by ameliorating pain, prolonging life, or even, at times, effecting a cure. Cripps very aptly says that any attempt to make excision the common treatment of cancer of this part would only bring discredit on the operation. He places the proportion of cases suitable for excision at from fifteen to twenty per cent, and in this respect agrees with most English writers, though the Germans, on the other hand, do not hesitate to subject to these radical measures about seventy-five per cent. It is, therefore, easily understood why the statistics are not lacking in figures that show a marked difference in the prognosis given by these two classes.

The methods employed number about twenty, but they represent only three general classes; they are the perineal, the sacral, and the combined perineal and sacral. The perineal is employed mostly for growths about the anus. The sacral is most useful when a circumscribed growth is present too high for the perineal plan and too low for laparotomy. It possesses the advantages of giving better access to the parts, sometimes preserves the sphincters and admits of manipulation under the supervision of sight as well as touch. The combined method makes it "possible to either resect long pieces of rectum or to amputate long portions which would have been" otherwise "inoperable on account of their distance from the perineum." It offers the advantages of attacking the growth from below, gives the greatest amount of working space, and enables the operator to reach the highest point in the pelvic cavity. Goodsall reports a case in which the operation was preceded fourteen days by an inguinal colotomy. After this a cancerous mass, extending four inches up, was successfully excised. Attention is called to this as an illustration of the fact that a preliminary colotomy is held by some authorities as an important factor in the procedure, and indispensable to the welfare of the patient.

Of those cases in which an operation is indicated, Cripps holds that the offending mass must be freely movable in all directions, and there

should always be a fair chance of completely removing the diseased structures. He points out that the most promising ones are those which resemble an ulcer, are limited to one side of the gut, have the upper border well defined, and healthy mucous membrane beyond the growth that can be felt. Treves opposes the procedure when the peritoneum is opened or portions of the bladder, vagina, and prostate are removed, while Allingham looks with disfavor upon attacking the growth four inches from the anal orifice. These three writers may be said to agree in the main, and probably voice the opinion of most English surgeons. Kelsey substantially subscribes to these views, acknowledges the possibility of excising as much as six inches of the rectum, but doubts its advisability. McCosh, Lange, Kammerer, Gaston, and others, who favor the German ideas, go higher and open the peritoneal cavity with greater impunity. The former reports five cases in which from three to ten inches were removed successfully, while the latter gives one case where the entire rectum was excised, but with a fatal result. Kelsey maintains that a large proportion of cases still remains on undetermined ground.

According to McCosh, out of 439 cases carefully selected and operated upon by Kelsey, Cripps, Billroth, Czerny, Rehn, and others, including fifteen recorded surgeons, 84, or 19.1 per cent deaths were attributable to the procedure. This gives a mortality that is palpably still very high, notwithstanding the fact that these cases were treated under the best hygienic surroundings and with the most modern improvements in scientific surgery.

In the matter of prognosis, Kocher, Bardenheuer, Hildebrand, Czerny, Konig, Kronlein, V. Wahl, Von Bergmann, Genzmer, and Cripps give an aggregate of 375 cases. Considering an immunity from the disease for four years a cure, they report 32, or a little more than 8.5 per cent, cures. McCosh claims, however, that as it has not yet been four years since some of these cases were operated upon, this percentage can reasonably be increased to about 11.

From these figures one almost irresistibly reverts to the work of Paget, on Pathology, in which he says that in many phases of cancer it is even yet a question whether or not operations prolong life.

External Hemorrhoids. Operative Treatment. In the matter of local treatment of external piles Deaver, of Philadelphia, lays little stress on the accomplishment of a cure by palliative methods, and advises the three following operations: Incision for the thrombotic variety,

dilatation of the sphincters or clamp and cautery for varicosis with proliferation, and in the variety made up wholly of hypertrophied tissue, unless it be a mere tab, the latter operation should be employed.

It need scarcely be said that the weight of authority will not bear him out in all that he says. Assuming that an operation has been consented to, probably few will differ from the plan of dealing with the thrombus, nor yet with dilatation in some cases where fissure or sphincteric contraction is present, but when the clamp and cautery are applied to varicosis with proliferation there will be many dissenting voices. These will be not only among the advocates of this operation for internal piles, but also from almost all disciples of the ligature and other procedures. This class of cases, being usually very simple, scarcely ever justifies radical surgical measures, unless indeed it be a complication of internal hemorrhoids or fissure. Uncomplicated conditions demanding operation here are considered usually to require only such procedures as galvanism, the ordinary cautery point, or possibly the ligature. Allingham, Cripps, and others hold that careful clipping away of the redundant tissue with the scissors will suffice in hypertrophies. Kelsey maintains that it is not best to perform the operation when the parts are acutely inflamed, as there will be more pain and the recovery less rapid. He admits, however, when necessity requires it, that nothing is gained by waiting. It is now pretty generally accepted that necessity nearly always requires it, and the better rule would therefore be to excise the tumor at once. The pain, though more intense at the time of the operation, is less extended, and the belief that the convalescence is of shorter duration is still quite current among rectal surgeons.

Internal Hemorrhoids. Medical Treatment. Remarkably few plans of medical treatment have been brought forward since your last session, and of these only one needs even passing notice. It has been suggested by Keith MacDonald, of Great Britain. The agent used consists of Kosobudki's modification of Unna's suppository. It is composed of chrysarobin 1 grain, iodoform $\frac{1}{4}$ grain, extract of belladonna $\frac{1}{8}$ grain, with cocoa butter 30 grains, and glycerine in sufficient quantity for consistency. During treatment the patient is to avoid much exertion, keep the bowels well open, and introduce one suppository into the rectum each day. In the course of a fortnight the hemorrhoids slough away, and the patient is dismissed as soon as the wounds have sufficiently repaired. It should be said of this treatment, which represents a plan more generally practiced than is supposed, that it is as empirical as it is

uncertain, and the less it is employed the better it will be both for physician and patient. There is always danger of extensive inflammation, sloughing, ulceration or bleeding. In a well-marked case of internal hemorrhoids no radical cure can be effected unless the pathological condition be removed. This treatment can bring about such a result only through unlimitable sloughing; therefore its curative effect must necessarily involve an element of danger.

Operative Treatment. The subject of the use of the ligature and the clamp and cautery in the treatment of internal piles still continues a topic of discussion among many of the leading rectal men of America and Europe. The advocates of each, by facts and figures based on experience and the common disadvantages, show excellent results and claim precedence for the operation of their choice. The statistics of each, in the hands of experts, show about the same figures, and that they are both practically safe (as to life) when the operator is duly careful.

The generally admitted disadvantages that are common to both may be mentioned as follows: Hemorrhage, abscesses, sloughing, pyemia, erysipelas, tetanus, and the misfortunes of attendant pain, delayed healing, subsequent ulceration, fistulæ, and anal contraction. It is on these points mainly that the comparative merits of each have been discussed, but throughout the various controversies the ligature seems to have lost none of its popularity, and to-day the preponderance of authority singles it out as an operation *par excellence* for general use. Treves says of it, that personally he would share the opinion, shared by many, that the ligature offers on the whole the best means of dealing with internal piles. Allingham reports 1,600 consecutive cases operated on by him without a single death, and finds the clamp and cautery "four times as fatal as any other method."

While at St. Mark's Hospital, London, with the exception of but three cases, I saw no other operation than the ligature for internal hemorrhoids.

Aside from statistics and the deductions usually drawn in standard text-books, there seem to be one or two practical points that may be mentioned in favor of the ligature.

Regarding instruments, the practical physician who would use the clamp and cautery must provide himself with costly paraphernalia which he will seldom find occasion to use. The operation with the ligature, on the other hand, can be performed with a scalpel or pair of scissors, a

tenaculum, artery clips, and a good stout silk or flax ligature, all of which may be found in any ordinary pocket case.

The use of the ligature requires much less dexterity, skill, and experience for its application, and is therefore a much simpler method.

Should recurrent hemorrhage occur inside the anus, the ligature will serve at once as a guide to the bleeding point, which may be either caught up with an artery clip or possibly controlled by tightening the ligature already present. Should it become necessary to use a speculum, the dangers of tearing the tissues and exposing the mouths of the vessels are greater when the clamp and cautery have been used.

It will also be found that there is generally an aversion to the use of the cautery on these parts, when the nature* of the operation is explained to the patient. Many people will submit to the ligature who will vigorously oppose the other method.

In the preceding statements it must not be understood that the clamp and cautery are to be condemned as useless, nor yet that they are inferior to the ligature in every respect, but for the general run of cases, and in the hands of the general practitioner, the ligature offers under most circumstances a simpler and better means of dealing with this class of maladies.

Pain Following Operation. Treves calls attention to the fact that pain following the operation for hemorrhoids is attributable to spasmodic contraction of the sphincters or levator ani, an intercurrent inflammation, or inclosure of the skin, in case a ligature has been employed. For its relief he believes morphia and opium suppositories of doubtful benefit, since it is questionable whether enough of the drug is absorbed to produce any salutary effect. It may be further added that some suppositories, instead of being absorbed, remain solid and become an irritating substance to the adjacent wounded tissues. Local applications of hot water by means of a sponge, as advised by Henry Smith, of London, and administration of the agent hypodermatically or by the mouth will usually prove more effectual.

Colotomy. Inguinal versus Lumbar Colotomy. Mathews states that the preference for inguinal colotomy has been given such prominence by recent writers as to make the matter seem one-sided when compared with the lumbar method.

He brings forward a paper in answer to some of the generally accepted advantages of the former method, and believes that "the inguinal operation has not and should not supplant the lumbar operation as a surgical procedure."

The points taken are substantially as follows:

1. That the inguinal method being easier should be no argument in its favor, for it is in reality sometimes more difficult. The surgeon should be prepared to do either, and not advance such premises to palliate his inability.

2. That in the majority of inguinal cases the small intestine presents itself first. This often necessitates a prolonged and difficult search in the peritoneal cavity for the colon.

3. That the open peritoneum in the inguinal or intra-peritoneal procedure must invite dangers not attendant to the lumbar or extra-peritoneal (Bryant's 170 cases being cited as evidence) operation. The dangers are made greater when a prolonged search for the bowel is requisite. The recent adoption of antiseptic surgery in no way weakens the force of this proposition, as it can be better practiced in lumbar colotomy.

4. That the short inguinal incision, in his experience, frequently has to be lengthened to the extent of admitting two fingers, to make it possible to procure and handle the bowel. And in bringing the bowel to the surface there is danger of twisting it.

5. That he has never been compelled to resort to insufflation, as pointed out by some writers, to find the gut in the lumbar region.

6. That where the colon is distended, or there is a bound down or contracted mesentery, or carcinomatous disease involves the lower colon, the inguinal method would have to be abandoned.

Finally, he adds, "To the lumbar operation none of these objections can be preferred, and I must maintain that they outweigh any and all of the objections that have been preferred against it."

Complication of the Operation. Probably the most important fact that has been brought forward recently in connection with colotomy is what Kelsey terms evisceration. He reports two cases observed in three years, and claims that they are the only ones on record. It consists of a protrusion of the intestine through the abdominal incision, and takes place usually within twenty-four hours after the first dressing has been applied. The onset is sudden, and marked by a profuse exudation of serum which quickly saturates the dressing. The cause was attributed to diminishing the number of stitches used in the operation, from about fourteen to six, and its prevention likewise suggested, as suturing the parts more carefully and firmly. I might also add here that a good firm pad and steady manual pressure over the parts during

the subsequent coughing and vomiting will do much to obviate this untimely accident.

In the matter of treatment he advises that the adhesions to the dressing be gently separated, the impaired circulation revived, the protruded colon returned to the abdominal cavity and kept in place by a reinforcement of sutures and a well-applied dressing. While the lack of reports points to the infrequency of this complication, its occurrence in these two cases is quite sufficient to impress upon us its dangers and the necessity of always employing such measures as will anticipate and prevent it.

Restoration of the Rectal Function. After a colotomy has been performed and it becomes desirable to re-establish the flow of feces in its normal channel, the following method has been suggested by Banks, of Liverpool: Select a substantial piece of soft rubber tubing about six or eight inches long, tie a stout ligature firmly about its center, and introduce it into the artificial anus in such a way as to have about half of its length on either side of the abdominal opening, where the bowel is acutely bent. The ligature may be made fast to the dressings or, by making it sufficiently long, can be carried around the waist and tied.

In this manner placed, the tube tends to return to a straightened position, and in doing so produces a similar effect upon the bowel. The greatest pressure is therefore exerted upon the spur, and in consequence causes it to melt away more or less by atrophy, absorption, or ulceration. This process is simple, practicable, unattended by any great amount of risk, and in the hands of Mr. Banks has brought forth very good results. When it is remembered that the use of ligatures, clamps, caustics, or incisions, may give rise to a fatal peritonitis in this operation, and that not time so much as safety is the great purpose, this method should always deserve, indeed demand our first and most careful consideration.

Fistula. Fistula with Phthisis. From an article recently published on the "Relations of Pulmonary Phthisis to Rectal Fistula" Strauss, of St. Louis, draws several deductions, which are substantially as follows:

In selected cases of fistula in phthisical persons it is safe and the surgeon's duty to operate. The results are very satisfactory, since by curing the local manifestation with its additional drain on the system, improvement in the general health quickly follows. He thinks that opposition to operation is the outcome of an improper understanding

of the etiology and pathology of this disease. There is probably no surgeon who has given this subject more careful attention nor pointed out the relationship of the two conditions more clearly than Allingham. He holds that the subject from an operative standpoint should be considered as taking the three following forms:

1. "Fistula with acute tuberculosis." The patients so affected are "acutely tubercular, and can not live long."

2. Fistula with chronic phthisis. In this form those affected "have had hemoptysis, and may at the time of consultation have the remains of a cavity or consolidation at the apex of the lung without any very active symptoms of phthisis."

3. "Fistula with a family tendency to phthisis." These cases are considered as synonymous with strumous disease in other portions of the body.

In operating on the first variety he advises that the external opening be simply enlarged, using an anesthetic if necessary, the object being to establish free drainage and give relief from the pain. In the second class the object to be accomplished is a cure. The procedure consists in laying open the principal tracks, cutting off all superfluous flaps, and scraping the sinuses with a curette. Care should be taken here, as in both the other varieties, to "interfere as little as possible with the sphincters" ("especially the internal"), and to reduce the loss of blood to a minimum. In the third variety the plan of procedure differs in no respect from that usually followed in the ordinary form of fistula, of course bearing in mind the injunction regarding the sphincters.

It is of signal importance not to confine the patient to bed any longer than necessity requires, and always to select good weather for the operation.

When constant cough is present, unless it can be controlled, an operation for cure should not be advised, for the reason that the continuous motion caused by it prevents the proper healing of the parts.

The omission of several very interesting articles from this report can be attributed only to the fact that they have seemed less important than the preceding ones, and the time allotted would not give them place.

LOUISVILLE.

APPENDICITIS GANGRENOSA; OPERATION; RECOVERY.

BY H. M. GOODMAN, M. D.

Pathologist and Bacteriologist, University of Louisville.

On August 12, 1892, I was called to see Mr. X. He had been feeling badly for one or two days, complaining principally of a pain in his side. His tongue was coated, breath offensive, pulse 120, temperature 103° , bowels constipated, and he had several attacks of vomiting. The abdomen was markedly tympanitic, and diffuse abdominal pain was present, but the most severe pain was referred to the right iliac fossa. The whole abdomen was tender, but was especially marked at McBurney's point, about two inches from the anterior superior spine of the ilium. The abdominal walls on the right side were rigid and the legs flexed. The patient, a large and powerful man and a hearty eater, stated that the day before he had eaten rather heartily at breakfast of raw tomatoes, orange peel preserves, bread, and steak. Sometime during the day he had begun to feel slight pain, which had so increased in intensity that it became unbearable, and he had sent for me.

A diagnosis of appendicitis, resulting from the presence of tomato seed, was given, and fears were expressed that the case would possibly become surgical. My first efforts were directed toward evacuating the bowels, ordering salines internally, to be followed, if necessary, by enema. Hypodermic injections of morphine and atropine were given to control pain. In spite of purgatives the bowels were not freely opened, only one or two small motions being secured. Turpentine was given to relieve the tympanites, and hot opium poultices were placed over the principal seat of pain. This treatment was maintained for the first seven days without any marked change in the condition of the patient. Toward the close of the eighth day the pain over the colon suddenly ceased, and the tenderness, even on deep pressure, was hardly perceptible. The axillary temperature remained about 101° , and there was no indication of collapse. The patient complained of pain in the loins about an inch below the twelfth rib, and upon examination a distinct swelling was discovered, which was very tender on pressure, indicating the formation of an abscess.

Upon my advice my friend Dr. Vance was called in consultation. After a thorough examination, being unable to detect fluctuation, the doctor expressed the same opinion, and advised waiting forty-eight

hours, unless some alarming symptom developed in the mean time. The same treatment that I had established in the beginning was maintained, and I saw the patient at intervals of every four hours during the day, and once at night.

About four o'clock on the morning of August 22d I was suddenly summoned to the house. I found the patient wildly delirious for the first time, and the axillary temperature 105° . Examination over the site of the swelling showed marked fluctuation, and an hypodermic needle thrust into the tumor showed pus. Believing that the condition was due to the absorption of septic matters, I sent for the assistance of Dr. J. M. Bodine. After chloroforming the patient, Dr. Vance made the incision through the abdominal wall opening into the subperitoneal space at a point above the middle of the crest of the ilium, and about one inch below the twelfth rib. About two pints of a foul smelling pus was evacuated. The wound was then irrigated with hot water, and the necrosed appendix, with the fecal casts and considerable grape and tomato seed, washed out. There was no evidence at the time of the operation of a permanent fistula, and the gut at the point of separation had evidently become thoroughly agglutinated. An hypodermic of morphine was administered and the wound dressed, and the patient made comfortable in bed. Two grains of calomel were given every half hour until six grains had been taken, and this was followed by one half bottle of a solution of citrate of magnesia containing one half ounce of Rochelle salts, and repeated in four hours. By two o'clock in the afternoon his bowels were freely opened. On the morning of the 23d the axillary temperature was 100° , and the patient had become perfectly conscious. Whisky and a fluid diet were ordered, and the tympanites relieved by purgation. The temperature became normal next morning. The patient made a rapid recovery, and was able to go out of doors seven weeks after the operation.

My object in reporting this case is to call attention to certain points of interest in determining the proper cases for operation. Had this patient been operated on in the usual manner, and the peritoneal cavity opened, I am satisfied he would have died. As it is, I am now satisfied that we are justified in waiting before subjecting the patient to an operation that may add to the existing inflammation. Had this patient had an indicator inside his body to determine the proper time to operate, it could not have been selected more opportunely, as subsequent events have shown.

Following the latest authorities, I think the subject is best considered under the following classification of cases: (1) Non-suppurative appendicitis resulting from ulceration or catarrh, attended by local peritonitis, which tends to recovery by resolution, but which is exceedingly liable to recur. (2) Perforative peritonitis terminating in suppuration, which results either in local abscess or diffuse peritonitis.

In the former class of cases I am inclined to think that surgeons, as a rule, are entirely too prone to advise immediate or early operative procedures, with the result that many lives are sacrificed that might have been saved had a more conservative course been pursued. Certainly I do not think we are justified in advising an operation for the removal of the appendix in all cases on the second or third day in the first attack, though sometimes this is doubtless the wiser course to pursue. If, after recovery from one attack, the patient should be taken ill for the second time, I think we are justified in advising an operation on the second or third day, with a view of removing the offending organ and permanently relieving the patient from further danger. If the operation is not undertaken during the attack, and the patient recover for the second time, the operation should certainly be advised during the intermission.

Seven years ago I attended a young lady who was a great sufferer from chronic relapsing appendicitis. She had six or seven attacks in three years and a half, and finally died. Had I known then what I know now, instead of trusting to opium, rest, diet, and purgatives, I believe her life might have been saved by operation.

In the second class of cases the question as to the proper time for operation is, in my opinion, much more difficult to decide.

During the time that I was assistant demonstrator of anatomy in the university I opened some one hundred and fifty abdomens. If memory serves me right, I think I can safely say that in more than fifty per cent I noticed that the appendix had its own mesentery. In the other cases the appendix was so situated that a perforation would have opened into the subperitoneal tissue. It is of course impossible to determine this condition prior to laparotomy, yet I am positive that we are not justified in operating early in the attack in all cases, in view of the possibility of the position of the appendix. If the appendix has its own mesentery, perforation must necessarily open into the peritoneal cavity in the large majority of cases; in fact, I should say in all cases. On the other hand, as in this case, it may open behind and not involve the peritoneum at all.

When I first saw this patient, as already stated, the pain and tenderness was most marked over the region of the appendix, but there was no evidence of a mass to be detected even upon deep palpation. Suddenly, in the afternoon of the eighth day, the pain on deep pressure over appendix ceases, and the patient complains of pain in the back, radiating toward the front on a level with the appendix. Examination reveals the presence of a very perceptible lump about an inch and a half below the last rib, the temperature remaining the same, and there being no indication of collapse, the conclusion was forced upon me that an abscess had formed behind the peritoneum. My first determination was to have it opened at once, but upon due consideration and the advice of Dr. Vance I determined to wait until fluctuation appeared over site of abscess.

In the light of experience afforded me by this case, should it ever again befall me to attend a case with similar symptoms, where physical examination does not define clearly the position of the appendix (by abdominal palpation, showing a tumor, or by rectal examination) to be anterior, I shall be inclined to postpone operative procedure, in the hope that the abscess may form behind the peritoneum. Where the appendix is clearly situated anteriorly it is presumable that it is inclosed in its own mesentery, and delay in operation may kill the patient through perforation into the peritoneum. Under such circumstances the sooner the operation is performed the better the chance of the patient to regain health and strength.

LOUISVILLE.

REPORT ON GYNECOLOGY.*

BY JOHN G. CECIL, B. S., M. D.

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Without undertaking to consider the modifications and improvements in detail of the various operations in the gynecological field that may have been suggested since the last report was made to this Society, it will be the aim of the present paper to present for your attention the trend of current opinion of the status of this important and ever growing specialty.

The tide toward conservative work in gynecology has set in in no

*Read at the May Meeting of the Kentucky State Medical Society, 1893. For discussion see p. 469.

unmistakable manner. It is assuredly gratifying to all not afflicted with the cutting fever to see men of ripe experience and sound judgment entering strong protests to the promiscuous unsexing of women, and the relegation of all obscure pelvic or abdominal affections to the relentless arbitration of the knife. During the past twelve months current literature has not abounded so luxuriantly in articles under such captions as "My First Hundred Laparotomies," "My Year's Work in Gynecology," "My Last Twenty Cases of Hysterectomy."

The time has come when something more than the simple enumeration of so many cases with so many successes and so many failures is necessary to establish an enviable reputation as a gynecologist. The ability to cut a hole in the abdominal wall, pull up, ligate, and cut off a pair of innocent and unoffending ovaries and tubes in just so many minutes is not of a truth the mark of a great pelvic surgeon. This day and age demand more; the demand is careful and painstaking examinations, clear indication for operation, a reasonable promise that the proposed surgery will give relief. "To open or not to open" is not so much the question as "Why should I open, and what good will be accomplished by so doing?"

A word in this connection concerning exploratory incision will be permissible. In these latter days of clean surgery this can not be regarded a dangerous procedure, but has not this inestimable privilege achieved by the spirit of modern progress been sadly abused? Has not this been resorted to before the other and less heroic methods of diagnosis have been exhausted; and have not the abdominal and pelvic cavities been explored to find something which could not before be found, a something of which there existed very vague evidence? Have not appendages been brought to light that were innocent of disease and guiltless of offense; and have not these same appendages been sacrificed, because forsooth the hunter did not wish to return empty handed? I verily believe it requires more courage to drop a healthy ovary, whose personal character has been under suspicion, back to its place and close the incision, than it does to make a complete operation. A more critical study of pathological and normal specimens would be productive of great good, and would prevent repetition of this mistake. Such is the abuse that this very necessary diagnostic measure has suffered.

The time has also come, after a quarter century of brilliant and apparently successful surgery whose parallel is not approached in all the preceding centuries, when we ought to hear more of the ultimate

results, more as to what time, that great solver of problems, has wrought for that fortunate female whose medical history is recorded somewhat after this fashion:

"Mrs. X, white, aged thirty, primipara; great sufferer for three years from dysmenorrhea. Operation October 20, 18—, by Dr. A, assisted by Drs. B, C, D, and E; E giving the anesthetic. Both tubes and ovaries, which were cystic, removed. Drainage-tube for fear of hemorrhage. Time, twelve minutes and thirty seconds; tube removed second day; stitches out eighth day; discharged cured fifteenth day—being the seventy-third in my second series."

Every one in this audience would read with keenest interest a paper by Mr. Tait or Mr. Keith, giving a retrospective account of his first hundred cases, with remarks as to the final outcome in each case.

Many are the trachelorrhaphies that have been done on slight lacerations, for the cure of nervous manifestations, that have been utter and dismal failures; nay, more, that have resulted in a condition more deplorable than the original, and demanding abdominal section for relief from the damage directly attributable to the trachelorrhaphy. Many dilatations of the cervix uteri and curettings of the endometrium have been followed by lasting injury in the shape of pelvic peritonitis. Many restorations of the pelvic floor were restorations that did not restore.

It is an easy step from this to a brief mention of the criticism that has been heaped upon the heads of the minor gynecologists and general practitioners by the major operators for this indiscriminate use of the sound and iodine-tipped applicator. A defense of these unfortunate gentlemen is not called for at my hands. They are abundantly able to take care of themselves; but I never could understand why the cutter should bear down so hard on the goose that laid the golden egg. Perhaps it would be as well for him to give attention to harvesting his own luxuriant crop of sins. To a man with even a dull imagination, who had never seen a uterine sound, a recital of the horrors that follow its ordinary use would picture to him an instrument as complicated as a type-writer. But seriously, while it is conceded that the uterine sound has a very limited sphere, that the vaginal speculum may sit on too high a pedestal, and that local applications to the uterine mucosa are often not only useless but harmful, very much that we see in print and hear in society discussions as to their baneful influence may be justly characterized as gynecological demagoguery.

The year past has developed a more conservative estimate of the very formidable operation of hysterectomy for fibroid tumors. The simple existence of a benign growth of this character, the diagnosis of which is usually not very difficult to make, does not justify the risk attendant upon so dangerous an operation. Too many women have carried these tumors through scores of years, living useful and happy lives, to make a plea for their universal removal tenable. The indication for extraction must be plain and urgent. Some of the reasons justifying an operation are: Profuse, obstinate, uncontrollable hemorrhage; unmanageable interference with the function of neighboring viscera; great size of the tumor, making life useless and burdensome, and pronounced general depreciation of health, attributable to the growth. The less formidable operation of removal of the ovaries is to be preferred in the majority of cases demanding any interference.

A striking feature of the mutability of times and minds is the rapid growing distrust of antiseptics. A new antiseptic idol is no sooner set up than it is thrown down and broken. The simplicity of the master operators is simply admirable. The only two agents that defy the attacks of time and the idol breakers are soap and water. The sterilization of instruments, hands, dressings, etc., is so simple that no one should err. The germicidal agents that for years have been deemed indispensable now either play an insignificant role or are consigned to the limbo of not only useless but harmful trumpery. Our best lessons, truly, are learned through our mistakes.

Another and hardly less important lesson in the after-management of surgical cases is the almost universal abandonment of the use of opiates. Very few cases are benefited by or really demand the hypodermic use of morphia that for a long time was so generally administered. Some of the reasons that condemn its use are prolongation of the nausea and vomiting from the anesthetic, the delay of prompt reaction, the arrest of the secretions, and the masking of important symptoms as they may arise. Nature untrammelled is the best restorer. Quite a lengthy article might be written upon the abuse of opium, or the advantages of not using it in surgery.

Operators who sacrifice thoroughness of detail to haste, or who operate against time, generally have occasion to repent at leisure. Not one moment more than is necessary should be taken, but to take less is exceedingly unwise. Much otherwise good work must be undone because of undue haste, and, on the contrary, many failures may be

assigned to continued exposure of viscera, needless delay, and faulty preparation.

More and more is the gynecological field being narrowed down to operation for organic disease. Psychical and functional disturbances are seldom benefited by surgical measures. This view is now so generally admitted that further discussion of it is unnecessary. Closer attention on the part of the general practitioner in following up cases of gonorrhea until thorough cure is established, and unvarying adherence to thorough asepsis in the management of labors and abortions, will do much to limit the necessity for gynecic surgery. Could these two prolific sources of pelvic disease be eliminated, a large proportion of the work of the pelvic surgeon that now is imperative would be forever relegated to the history of the past.

LOUISVILLE.

REPORT ON OBSTETRICS.*

BY T. S. BULLOCK, M. D.

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The yearly reports on the various branches are styled "Reports on Progress." It is a matter of congratulation and a credit to the profession that seldom a year elapses unmarked by an addition of greater or less value to our store of useful knowledge. Former reporters have shown to this Society the predominant influence which has been exerted by antisepsis and its offspring, asepsis, upon the practice of obstetrics. As in surgery, so also in a somewhat less degree has antisepsis given place to asepsis. Both have for their purpose the accomplishment of the same object, as both are but other names for systematic and painstaking cleanliness; as not infrequently both the patient and the accoucheur are the victims of an idiosyncrasy that renders the exhibition of the antiseptic in general use both disagreeable and harmful, the change will be a welcome one. It is the strict observance of these principles that renders possible the simplest operative procedure without an increase in the risk to the mother. A rigid adherence to antisepsis or asepsis enables us to elect operations which have in view the preservation of two lives. One was formerly invariably sacrificed, and the other greatly jeopardized. The revival of symphyseotomy, considered

* Read at the May Meeting of the Kentucky State Medical Society, 1893. For discussion see p. 468.

by many the greatest advance in recent times, and the success which has attended its revival, together with the new cesarean section, enables us to confidently assert that embryotomy upon the living child, monsters and hydrocephalics excepted, is a thing of the past.

A brief resume of symphyseotomy may not be amiss. It was first practiced upon the living woman by Sigault in 1777. It was received with great enthusiasm, but was so abused and misapplied and the results were so unfavorable that it speedily fell into disrepute and was practically abandoned except in Italy, being characterized as "murderous and unphilosophical." Note the results of the first forty operations collected by Dr. Robert P. Harris, of Philadelphia: Women recovered, 15—died, 25; children saved, 12—died, 28. In addition to this fearful mortality it was found that necrosis of the pubic bones not infrequently occurred and that lameness often resulted. Contrast with this the results attending its revival with asepsis and an improved technique. In 1892 Dr. Harris collected twenty-six cases; there were fifteen operations in five different countries, and no maternal deaths. The number of children saved not stated. Up to date there have been fourteen operations in the United States, with two maternal deaths, neither of them traumatic. In no case has lameness resulted, convalescence being complete, and the patient walking without difficulty at the end of a month. As to after-treatment, no complicated apparatus is necessary, the mere fixation of the pelvis with broad strips of adhesive plaster or a canvas binder being all that is needed. The operation itself is not especially difficult. It may be done through an inch and a half incision, and this does not have to be extended through the skin nearer than three fourths of an inch from the symphysis, the rest of the cutting being within, with the Galbiati knife, without injury to the urethra, bladder, pubic artery, or peritoneum. Most of the foreign operators cut from behind forward, and claim that there is less danger of injuring the urethra and bladder. Dr. Harris advocates this method, but other American operators cut from above downward, and state that the hemorrhage which takes place from the lower end is more easily controlled.

The following is a description of the mode of performing the operation according to Dr. Harris: "The armamentarium consists of a scalpel, a Galbiati knife, hemostatic forceps, needles and needle-holder, gauze, and ligatures. Although it may be performed through a small incision, its length will depend upon the depth, thickness, and direction of the symphysis. A metallic catheter is introduced and the urethra

depressed and carried to the right. An incision is made through the skin and fat above the pubes two and a half to three inches in length, ending about three fourths of an inch above the symphysis and passing to the left of the clitoris. The interosseous ligaments and cartilage are now divided from within outward and below upward. The bones then separate from one to two inches. Dr. Harris, after a thorough and exhaustive study of the subject, states that two inches and a half of separation on the average are all that should be claimed as safe in the living woman, although three inches and even more have been attained in operating, where the patients made good recoveries and were able to walk at the end of a month. All the pelvic diameters are increased. The object of the operation is the delivery of a living child, with a minimum of risk to the mother, and is to be regarded as a failure if the child is still-born or dies in a few hours.

It has been suggested by Dr. I. Edwin Michael, of Baltimore, that the sphere of symphyseotomy is not limited to pelvic deformities. He says there are cases in which it is more imperatively demanded than in contracted pelves. There are face presentations wherein anterior rotation of the chin does not take place. In such a case, if version were impossible, with a fixed and jammed chin, nothing could be gained by delay, and formerly embryotomy was the only procedure practicable. He, after experimenting with a fetus and a pelvis with the soft parts attached, is convinced that the operation of symphyseotomy is perfectly feasible, and states that he will attempt to so deliver the first suitable case presenting, and asks that it be given a trial.

The outlook for symphyseotomy is certainly encouraging, and it bids fair to win for itself a permanent and honorable position as a life-saver. The danger is that it will be again brought into disrepute by becoming the fashion and being unwisely and unadvisedly performed. It is certainly a safe operation, and when it is brought into competition with the cesarean section will doubtless carry the day both with the patient and her family. It can never compete with the cesarean section under the absolute indications, but is destined to displace the relative section. The conditions necessary for a successful performance of the operation are, according to Dr. Wihle, of Dresden: "(1) Freedom from infection; (2) the pelvis must not be ankylosed or have an extreme oblique contraction; (3) the fetal heart sounds must be good. Desirable conditions are that the woman be a multipara, and that the soft parts be sufficiently prepared." It is safer than the cesarean section in about

the ratio of three to one; but embryotomy is safer than either, and will continue to be done, as it requires less skill, and the life of the mother is regarded, and I think justly, the more valuable by far.

The question of embryotomy is one neither of religion nor sentiment, but the average practitioner remote from aid will continue to sacrifice one life rather than risk both by the faulty performance of a capital operation.

In connection with symphyseotomy the question of pelvimetry has been made prominent. Dr. Grandin, of New York, says: "It is the question of the day." When an interne in the Maternity Hospital of New York, in 1884-5, it was routine practice to ascertain the measurements of the various pelvic diameters with a pelvimeter and record them. Since that time the only pelvimeter I have employed or seen employed is the examining finger.

The only embryotomy on the living child I have ever seen was in hospital practice, though I have done it on the dead fetus. There is not a pelvimeter in Louisville to my knowledge, and yet it is seldom a mother is lost or that children are sacrificed, and our results will compare favorably with those of other cities. Accurate pelvimetry is a desideratum, and in cities with a large foreign population, like New York, is doubtless a necessity, but those of us whose province it is to deal with native-born Americans have not much need for it.

The tendency of the times, according to Dr. Grandin, is "to make of obstetrics an exact science." God speed the day! He makes an eloquent plea for exact methods in obstetrics, and says "guess-work and trusting to nature" is no longer to be tolerated. He further says, "that it is our duty as responsible men to familiarize ourselves with the configuration of the pelvis of every woman who intrusts herself to our care—a duty not to be shirked, and inexcusable if shirked." We are also to determine as accurately as possible the size of the fetal head. Armed with such information the physician will not make "prolonged and fruitless efforts to drag through the pelvis a child that can only come through at the expense of its life and the integrity of the maternal structures." The upshot of the whole matter, he predicts, will be the introduction into private practice of the exact methods which prevail in the Maternity Hospital. It is a melancholy fact that as a rule too little attention is paid to pregnant women. How many of us pay any attention at all to such patients, unless our attention is demanded by the occurrence of grave symptoms, until they are brought to bed! How

many of us even examine the urine at stated intervals! This is not as it should be, and is doomed to radical change. Does the fact that the vast majority of the *gravida* with whom we come into contact have natural labors render us less culpable? It certainly makes us extremely careless. While it is not proper in my opinion to regard labor as a pathological process, it might be better to so regard it, if by doing so we were rendered more careful and systematic. While it is not probable that accurate pelvimetry will soon become the universal practice, we should devote more attention to our patients. Our examinations should be more methodical and thorough. The hand is an excellent pelvimeter and has to be used to determine the true conjugate. We should not be satisfied with the determination of the presenting part, but ascertain also the position, the capacity of the pelvis, the probable size of the fetal head, if necessary even introducing the hand into the uterus.

The exhibition of ergot as routine practice after labor has been practically abandoned, it having been found to exert no special influence upon involution of the uterus. It is only given when demanded.

LOUISVILLE.

A STATE BOARD OF HEALTH UPHELD.—The Iowa Supreme Court has just decided the long-contested case of the Iowa Eclectic Medical College v. The Iowa State Board of Examiners. It was an action in mandamus to compel the board to recognize the college and grant certificates to graduates thereof, the board having refused on the ground that in its teachings and appliances the college did not come up to the requirements and standard fixed by the board. The plaintiff college claimed that the board had no power to fix the standard of a medical college, and that the statute was void in that respect; that the action of the board was had when there was no eclectic physician on the board, as required by statute in such cases, and therefore the action of the board was void. The court decides that the law is constitutional and valid, and that the board has the power to fix the standard of medical colleges, and that there is nothing in the statute requiring that any particular school of medicine shall be represented on the board.—*Medical Standard.*

Reports of Societies.

KENTUCKY STATE MEDICAL SOCIETY.

Thirty-eighth Annual Meeting, Frankfort, Kentucky, May 10, 11, and 12, 1893.

FIRST DAY, WEDNESDAY, MAY 10TH—MORNING SESSION.

The meeting was called to order by the president, Dr. Arch Dixon, of Henderson, at 11 o'clock A. M., May 10th.

The Rev. J. McClusky Blaynes opened the meeting with prayer.

The address of welcome was delivered by the Hon. Ira Julian, of Frankfort.

The report of the Committee of Arrangements was made by Dr. E. E. Hume, Frankfort, chairman.

Dr. John Q. A. Stewart, Superintendent of the Kentucky Institute for the Education of the Feeble-minded, tendered the Society an invitation to visit that institution.

The report of the chairman of the Committee of Arrangements was adopted, and Dr. Stewart's invitation accepted.

On motion of Dr. J. N. McCormack, of Bowling Green, the by-law requiring the Nominating Committee to report on the second day of each annual meeting was so amended that the report will in future be made on the third day, thus giving the committee ample time for the completion of their work before being called on to report.

FIRST DAY—AFTERNOON SESSION, 2 P. M.

The report on the Practice of Medicine was read by Dr. J. B. Marvin, of Louisville. Dr. Marvin said:

While no "epoch-making" discoveries have been announced since our last meeting, yet I think substantial progress has been made in several directions, and I shall very briefly call your attention to some of the more important advances, offering no apology for the rather sketchy outline presented; as I take it, it is the purpose of these reports to give brief summaries of progress during the year in the various branches of medicine.

Our friends, the surgeons, puffed up with their marvelous success, and desiring new worlds to conquer, have attempted to wrest from the practitioner nearly every region of the body. One of these attempts is to classify all the

affections about the cecum as appendicitis, claiming it as a surgical affection. The pendulum is swinging back, and I believe a more conservative view will prevail. The majority of these cases can be managed by the practitioner, though in a proportion of cases surgical interference is absolutely necessary.

Likewise the furor for craniectomy is subsiding. In a majority of instances the operation is irrational and ineffectual, the operator, losing sight of the fact that disease of the brain arresting its development is the cause of thickening or other manifestations of want of development of the cranium. Removal of parts of the bony framework can have no possible good effect on brain massed, atrophied, or sclerosed by previous disease.

Cholera has occupied a large share of professional attention at home and abroad. Every doctor is besieged with the query as to the probability of an outbreak in this country the coming season. Let us look at some of the lessons of the last outbreak. There were two outbreaks of cholera, one beginning near the Seine River, April 4, 1892, and spreading over France to the northeast, and the second coming from the far East in March, via Afghanistan, Turkistan, and Persia, into Russia, thence to the Baltic and North Sea ports to Hamburg, the two meeting at Antwerp and spreading to North America and England.

There can be no possibility of cholera without the comma bacillus; and it is equally obvious that the entrance of the bacilli into the system does not necessarily give rise to cholera. It is only when the system is in such a condition as to offer a culture medium for the bacillus that it will develop and produce cholera.

There are two extreme views as to the condition to which the greatest importance should be attached in this disease. First, that the sole etiological factor is the comma bacillus, and, second, that the greatest importance is by some attached to local and prevailing conditions. As is often the case the truth lies midway between the extremes, and to both these factors and to personal predisposition due importance must be attached in considering the prevention and cure of the disease. There is no doubt but that to prevent the introduction of the bacillus is to prevent the development of cholera. This is accompanied by isolation of the sick and disinfection of the excreta and every thing that comes in contact with them. During the epidemic in Hamburg there were 18,562 cases of cholera, with a mortality of 7,939, or 42 per cent, and in Kassan, Russia, the mortality was 51 per cent, although the treatment was by the most advanced scientific methods. A great deal has been said about antitoxic injections. Some investigators have been experimenting in this line upon the lower animals, and it has been claimed that a number of them have been rendered immune to the comma bacillus. Klemperer found serum from blood of the goat to be the most effective. Haffkine, a very able man from the laboratory of Pasteur, and now in India, claims to have isolated from the cholera bacillus certain

antitoxines, proteid compounds, albuminoses, or whatever you choose to call them, by means of which he has rendered animals immune, and it is claimed also by the public prints—no report having appeared in any medical journal so far—that in India he is meeting with success. I am inclined to believe that success will be greatest at the outset, and the longer it is tried the less effective it will prove. It is rather irrational to expect that by the inoculation of the toxic products of the bacillus in a disease like the cholera immunity can be secured. If one attack of cholera gave any immunity we might have greater hope from this treatment. So-called "intestinal antiseptics" are the will-o'-the-wisps of the present progressive therapeutic age. Salol, creolin, naphthalin, etc., have all failed, and calomel seems to be the best and probably the only antiseptic intestinal remedy. Hydronaphthal has been proposed by Stewart on theoretical grounds. Enteroclysis has been tried, and tannin injections have been used, two ounces to the gallon, water being heated to 104°. But still where this treatment was used there was a mortality of 52 per cent. A subcutaneous saline injections have also been used without much success. A saturated solution of camphor in oil, 20 to 30 drops, injected hypodermatically every hour has proved a valuable stimulant.

It is of the greatest importance that the water supply should be looked to. It is a well-known fact that cholera is a filth disease, and it seems to have a peculiar affection for certain classes; and the man who worships most at the shrine of Venus or Bacchus, or spends his substance in eating, drinking, and riotous living, puts himself certainly in the best possible condition for the entrance and destructive action of this microbe.

All have heard of Pettenkoffer's experiments in bacteriophagy, he going to the other extreme. I think, briefly, I can make this statement very positively, that the comma bacillus, while heretofore accepted as a laboratory fact, is now put on a firm footing and acknowledged by every one as the essential etiological factor of cholera. Without it we have no cholera; but the other proposition is equally true. I do not believe in exalting alone the bacillus; there must be the predisposition, and suitable soil and suitable climate—seed, soil, climate—and the mere swallowing of cholera bacillus cultures, as done by Pettenkoffer and Emmerich without the development of cholera in them, proves nothing whatever. The lesson of the Hamburg epidemic was that only three per cent of the people there had cholera. Pettenkoffer said he was old, toothless, diabetic, and still he swallowed the bacillus. If he had added that he was garrulous and had outlived his time, I think he would have done better.

Quarantine as generally practiced in times of peace is brutal and inhuman. As cholera is not indigenous to this country, rigid inspection at our ports of entry is of the greatest importance. Separate the sick from the well, keep suspects under surveillance, destroy infected clothing and other articles, keep discharges of cholera patients from entering water supplies, and the disease can not prevail in this country. Inland quarantine is a delusion and a snare. Let each community observe the ordinary laws of hygiene,

looking especially to a pure, uncontaminated water supply, and there need be no fear of the disease. Cholera is a water disease; it may be drunk or taken into the alimentary canal by food, but it can not be caught. I trust we shall never have a repetition of the barbarities practiced in New York harbor last year.

It has been claimed since our last meeting that the bacillus of measles has been discovered. It is a curious fact that the most contagious of the zymotic diseases are the ones about which we know least the etiologically. The bacillus of epidemic influenza (*la grippe*) seems also to have been discovered.

I will call attention very briefly to the recently discovered function of the thyroid in destroying or neutralizing some *materies morbi* in the blood. Remarkable results have been obtained in myxedema by the injection of an extract of this gland, slightly cooked; great amelioration of symptoms having been obtained thereby. The pathology of this disease is still in doubt. Acromegalia is a disease allied to myxedema. Great caution in making the diagnosis is necessary in various ways. The latter has also been treated by injections of the thyroid gland. Out of this has sprung a therapeutic delusion, in my opinion, which might be designated as sarco-therapeutics. You read a good deal in this country about Hammond's and others' use of cerebrine, cardine, etc., and claiming as a result almost to have discovered the elixir of life. It seems now that the miracle of transubstantiation is reduced to a formula, and the physician is brought face to face with the naked flesh. I, for one, would rather eat my meat cooked.

We have distinguished during the past year more clearly than ever before certain diseases, malaria, dysentery, and cancer, as not being bacterial at all, but as having for their cause animal, not vegetable parasites. Malaria is dependent for its cause upon a plasmodium or the ameba malarie; and, in the examination of the blood in malarial and all febrile troubles in which diagnosis is in doubt, it is important to distinctly diagnose these as differing from typhoid diseases.

The amebæ coli have been studied considerably and well worked out in this country, and their connection with dysentery and hepatic abscesses has been settled. In the latter it would seem that this parasite wanders about, punctures the gut, travels across the peritoneal cavity, and enters the liver in that way, and does not, as was formerly taught, pass up the blood current or the lymph channels.

Cancer is also claimed now to be a parasitic disease, but it would take an hour to give arguments *pro* and *con* for the existence of the parasite of cancer.

Following directly on the heels of sarcology a different form of therapeutics should be mentioned, which is attracting a great deal of attention, and certainly seems to hold out the promise of great usefulness, that is the specific treatment of infectious diseases by the injection, hypodermatically, of antitoxines; and in a recent publication in regard to blood serum and

therapeutics we read about immunity toxines, antitoxines, phagocytosis, etc. There are three theories here: first, the exhaustion theory; that is, when a man has any one of these infectious diseases the parasite, whatever it is, eats up or destroys something that is there and exhausts it, so that when the parasite again enters it can not find pabulum. That theory will not bear the test of criticism. The next theory is that of retention of antidote; this theory is also untenable; that is, the parasite secretes or generates something that is retained in the tissues and makes one immune. The third theory is the so-called tolerance theory; that is, that the system acquires tolerance or resisting power. This is more plausible. To my mind, however, phagocytosis is more probable than any of these theories, and if you will take the tolerance theory and the phagocytosis theory together, combine them, I believe you come nearer to getting a true idea of actual and acquired immunity.

Everybody believes a number of facts about inflammation which are common and trite. Metchnikoff radically differs from all other pathologists in some respects. He says that inflammation represents the reaction, so to speak, of the organism to irritants, that it is a matter solely of cells. He dethrones the idea of the preponderance of the nervous and vascular mechanism. These cells are lymphoid in character, and the irritants have the power of drawing the cells to themselves, called chemiotaxis. Having reached the irritant, be it a microbe or toxine, the cell devours it and renders it harmless. The cell is therefore a phagocyte, and inflammation is therefore a phagocytic reaction of the organism to an irritant. The legitimate deduction from this is that there are different kinds of leucocytes and irritants, a variety of chemiotaxis, and different kinds of inflammation, tuberculous suppuration, etc., and that inflammation can not be idiopathic, but must have for its cause some poison or infection or irritant. An inflammation tends to subside, it can not be kept up, unless the cause is continued. If the phagocyte destroys the cause, the inflammation must cease, it can not be idiopathic, it can not be continuous, therefore we are all wrong in classing certain diseases as chronic inflammatory. If this theory is accepted, chronic diseases, like chronic hepatitis, nephritis, etc., are misnomers, and now must be classed as degenerative.

DISCUSSION.

Dr. J. N. McCormack: Naturally I am interested in that portion of Dr. Marvin's paper devoted to the discussion of cholera, which embodies the latest and best views in regard to the pathology and means by which the disease is propagated. I think it is generally conceded by the best authorities, both in this country and abroad, that, so far as we are concerned on the Western Continent, there are three factors essential to the prevalence of the disease: first, that it shall be imported more or less directly from the only place on the globe where it originates, that is, India; second, that there shall be persons infected by the disease, or things infected by persons who have the disease, by which it may be carried from place to

place ; and third, such unfavorable local sanitary conditions as will favor the location and spread of the disease, and the development of the germ should it find its way into any particular locality. It might be of interest for me to state briefly what is being done by the State and National authorities to prevent its introduction and spread in this country, and then to emphasize in a few words the importance of such action upon the part of the health authorities and the medical profession and the people of the country, taking such active steps to improve local sanitary conditions that the germs of the disease will fall on sterile soil should they reach this country. I do not think there is any intention upon the part of any authority charged with the administration of any quarantine laws to enforce the harsh and oppressive kind of quarantine to which Dr. Marvin refers and against which there is such a just and well-founded prejudice in this country, and, for the old quarantine of detention, has been substituted in most of the great progressive nations of the earth a system of quarantine observation, especially with reference to cholera, which has for its intention keeping persons who have been possibly exposed to the disease under observation when they come into any new community, so that if they should unfortunately develop the disease they themselves may be kindly cared for, and cared for in such a way that the community may be protected. In accordance with that idea our own National Government, acting largely at the instance of the various State Boards of Health, has stationed medical experts at all the important ports of embarkation in Europe through which emigrants come to this country, and every emigrant now coming to the country is furnished at the port of embarkation with what we term an international health ticket, which is numbered with punch-marks easily and rapidly made, because these physicians have to handle a great many emigrants, 8,000 sometimes arriving at New York in one day. An emigrant, leaving St. Petersburg and coming to Frankfort, when he reached Hamburg would be furnished by a medical inspector there with a health ticket which would say whether or not at the time he left St. Petersburg he was infected with cholera, whether or not he had baggage, and if so, whether it had been exposed to infection, and if it had been disinfected, and if disinfected, how. It would say how many days he had been detained at Hamburg before he was allowed to embark for this country ; it would show the number of times that he had passed inspection while on ship-board, and the number of days that he had been detained at the port of New York. For instance, if he entered that port before he was allowed to take passage by rail for Frankfort, it would show then if the danger was sufficiently imminent to have railway inspection service established, for which the machinery is all arranged ; it would show the number of inspections he had been subjected to from the time he left New York until he reached Frankfort, and when he reached Frankfort, printed in the various languages would be instructions to the health office of the city of Frankfort to receive the ticket, which would be surrendered to him, and there the emigrant's name would be transcribed and the location

of the house in which he was to stay would be taken, and thus he would be easily kept under a kind of sanitary supervision, so that if he should be taken sick he could be handled at once safely and humanely, and kindly so far as he was himself concerned, and with safety to the community. Should a man come to Frankfort to-day who had been exposed to cholera, and that fact were known, we believe, if upon the development of the first symptom of the disease every discharge from the patient's stomach and bowels and every thing that could be possibly soiled by them were disinfected or destroyed, and due care was exercised upon the part of the attendants, such as washing the hands with disinfecting solutions, washing the lips and throat before any food was taken, with the use of all those precautions which are now so well understood by the medical profession, that the chances for the spread of the disease would be reduced to the minimum, which would be almost *nil*. These arrangements have been perfected with great care, and, as I say, the machinery has all been devised and will be put in operation in the event of an emergency, so that so far as the supervision of emigrants and persons coming from infected countries and infected places is concerned the regulations will be most satisfactory. The same rules would be put in operation if cholera should develop in New Orleans or New York, or if it should become epidemic at any of those points. But, unfortunately, we know from experience in past epidemics that with all these precautions in force, if the disease once reaches our shores and becomes epidemic at any point upon the continent, the means by which it is spread, the possibility of patients who have been exposed avoiding quarantine regulations or inspection, render the danger very great; that a man exposed in New York, owing to the long period of incubation of the bacillus, would be enabled to travel to Louisville, St. Paul, or Omaha before the disease would develop; that there is no means known by which it could be detected during the period of incubation; that in very many cases the cholera diarrhea produces so little sickness that it would escape observation even when the patient was infected by the disease itself, and yet that patient would be liable at every point where those dejecta were deposited, if local conditions were favorable, to establish a fresh center of infection.

The Report on Obstetrics was read by Dr. Thomas S. Bullock, of Louisville. [See p. 457.]

DISCUSSION.

Dr. J. G. Cecil, Louisville: I am very glad indeed that the doctor has seen fit to present to us certainly the most interesting living question in the obstetrics of to-day. We have all read with much interest of the revival of this old operation of symphyseotomy. I must say that until I saw the now improved methods of doing this operation I was much opposed to it; in fact I regarded it as entirely unsurgical. I take it that my prejudice arose from the fact that nearly every text-book either condemns the operation or says very little in favor of it. I believe, with Dr. Bullock, that the

indications for this operation are perhaps less frequent in this country among our strong, healthy, well-developed women than in the countries of Southern Europe, especially Italy, where it has its origin. We seldom see those deformed women that demand the great obstetrical operations for delivery. I can not recall in my obstetric experience many cases in which this operation would have been suitable. One class of cases which in this country we will find demanding operation are those in which every diameter of the pelvis is shortened, and I believe that this operation will be found advisable in many cases in the place of the dangerous and sometimes fatal use of the forceps, fatal especially to the child. I, for one, hold myself in readiness now to perform this operation in suitable cases. I do not think that in badly deformed pelvis it is as good an operation as the improved cesarean section, and if I should be called upon to decide in favor of an operation in a case of very oblique pelvis, I should certainly favor the Sænger operation.

Dr. M. F. Coomes, Louisville: The operation would seem to be called for under certain very rare circumstances; but during a number of years of obstetrical practice I never found a case in which I thought it was demanded, in which some other operation was not equally as good. I think in all cases where the forceps can possibly be used they should be used, since they involve no mutilation of the mother. In an extreme case I believe I would be tempted to do craniectomy rather than perform the operation of symphyseotomy. There may be cases in which this operation would be appropriate, but I have never seen one. However, Dr. Bullock's paper gives the present views of the profession in the matter, and the operation may be the coming one.

Dr. E. E. Hume, of Frankfort, read the Report of the Committee on Credentials. Upon motion the report was adopted.

The Report of the Committee on Gynecology was read by Dr. John G. Cecil, of Louisville. [See p. 453.]

DISCUSSION.

Dr. J. M. Mathews, Louisville: I quite agree with the author that a great deal of unnecessary surgical work has been done by gynecologists, and perhaps by other surgeons; but we must all admit that if we condemn exploratory incision as a rule we leave untouched and consequently uncured many hundreds of women that could possibly be saved by an operation. I like conservative surgery; I am an advocate of it; but by the wholesale to denounce the methods that are adopted to-day I believe is unscientific. Dr. Cecil well recognizes the fact that in the special surgery to which he is devoted it is quite agreed that exploratory incisions are advisable. I do not believe that any gynecologist or other surgeon can determine before an operation is done whether there is a pathological change existing or not. I will only cite you to the operations that are done for the removal of the appendix. We know how vague are the symptoms, how often we are mis-

taken, and consequently we have relied upon a medical treatment of these cases until the termination has been a fatal one, and the autopsy has revealed the fact that by an operation such a case or cases could have been saved. I ask you, in this case, if an incision here, under these circumstances, would not have been justified. In many cases no doubt there are presented to the gynecological surgeon pathological conditions after he has entered the abdomen only; and not before the incision has been made can he tell of the adhesions, etc., that may exist outside of any well-defined tumor that any surgeon could diagnose; that it is then and then only that he can tell what operation is justifiable; and in many cases, if the operation had not been performed, there would have been a fatal result. In other words, I imagine that exploratory incisions are frequently absolutely necessary; that there are many cases presenting themselves to the surgeon where, if he waits for plain evidence of a pathological change existing in the abdomen, he will fail to get it; and, recognizing the fact that the simple opening of the abdomen or exploratory incision in this day of modern surgery is a very simple matter, the surgeon is justified in resorting to it for diagnosis alone. A word as to the author's reference to the antiseptic and aseptic precautions employed in these cases. It may be true that soap and water can accomplish what we want, but I believe with Sir Joseph Lister that aseptic surgery is, to say the least, impracticable. In a majority of cases wherein the gynecologist especially is called to do his operations, in the homes of the poor certainly, and often in the homes of the rich, he can not follow out any recognized rules of aseptic surgery. I can not quite understand why it is that the gynecologist more than any other surgeon is fighting the so-called antiseptic treatment of wounds, or the precautions as taken in all operations in surgery. It can not be doubted that the introduction of antiseptics or chemicals into the abdominal cavity should not be practiced, but in the general treatment of the operation and preparation of the woman preparatory to delivery, and to prevent the sequelæ the author speaks of, I can not comprehend why he should rule out antiseptic precautions. I believe that antiseptic precautions are with us to stay, because these precautions accomplish more than soap and water can. Cleanliness is well, if one can get surgical cleanliness, but I doubt if in simple obstetrics or gynecology one can often obtain this thorough surgical cleanliness. Therefore I am in the habit of advocating and practicing the use of antiseptic solutions in my teaching and work as a surgeon.

Dr. H. H. Grant, Louisville: It occurs to me that a great part of this criticism has been directed, not against the competent surgeon but against those who make inaccurate diagnoses, or can not institute the proper surgical procedures after an accurate diagnosis is made. Dr. Cecil says the advance of the past twenty-five years can not be paralleled. He refers to this progress as growing out of improved technique, but he does not mention what is the outcome of this—that all forms of putrefaction are the result of germs, and that putrefactive changes are not only prevented by

cleanliness, but may be held in check by the germicides. If this be true, then, failing to prevent the access of the germ to such structures as favor their development, we have still in our hands powerful agents for their destruction. Much the same sort of objections were made when the old stage-coaches were abandoned for railroads. Many who failed to see the advantages that were to be obtained by the new method deplored the loss of the pleasant means of traveling afforded by the stage-coach, and took to the railroad with manifest regret. It is possible to see that, while means of asepsis are more or less effective under favorable circumstances, we will have an additional aid to progress in the means that are offered us in the destruction of germs established in the fresh wounds made not only by the gynecologist but by the general surgeon. In a recent paper published by Prof. Rein, of Paris, comparison is made between certain results that are obtained upon patients subjected to all the careful means of asepsis. Patients brought before him are rendered thoroughly aseptic, not only by soap and water, but by germicidal means. Thus, when the abdominal cavity is opened the immediate incision is mopped with sterilized gauze, which is subjected afterward to microscopical examination, as well as to the measures of cultivation of probable germs that might have found residence on it. After the operation is completed the surfaces of the intestine and the immediate incision are again mopped. This gauze is also subjected to the same means. Out of twenty-three cases treated in this way, nineteen cases wherein the gauze was applied to the fresh incision failed to show any evidence of germs. When, however, in these twenty-three cases the fresh surfaces were mopped with gauze after the operation (these surfaces having been exposed to the atmosphere for a period of fifteen or twenty minutes) the gauze in seventeen of them showed upon culture evidences of germs. Than this there can be no more positive proof of the fact that it is impossible, even if thorough asepsis has been provided in the beginning of an operation, to prevent the access of germs to the wound during the period of its exposure to the atmosphere. In removing, then, these causes, in wiping away these germs, in preventing the accumulation of septic material that results when these germs have access to a fresh wound, we demand and are in need of some other means than asepsis, and these means are offered to us in the germicidal solutions which have been recommended to us, and which have been tried and found to faithfully accomplish all the indications. For this reason alone, if for no other, it appears to me imperative that we should retain these means under all conditions favorable to applying them. Although I have no authority to speak on that subject, it may be that in the abdominal cavity, under such conditions as Dr. Cecil usually operates, it is unwise to apply strong germicidal solutions. It is not my habit under any circumstances to apply them there; but if this is the case, there is no reason for sweeping away from us the great safeguard that we have in the germicidal solutions applied under other circumstances of general surgery; and I regret that there should be advanced in the presence of

this Society such a proposition, and that a position should be taken so strongly as Dr. Cecil has taken his in opposition to the known advantage and the very great potential aid that has been derived from the application of these principles. I should be very sorry if any member of this Society were to hesitate either to apply a germicidal solution to the fresh wound in a safe locality, or to irrigate any septic wound with a strong germicidal solution because of the recommendations of Dr. Cecil. Although he does not say that he restricts these observations entirely to abdominal surgery or to gynecology, the inference is very naturally drawn that because he believes they are inefficient there they are inefficient elsewhere. I commend the paper heartily in as far as it applies to conservative surgery, but there can be no conservative surgery which partakes in any way of ignorance; there is only one class of operators who can expect to rise to any degree of prominence, and that is those who have the proper attainments. My objections, then, to the paper are two-fold: that instead of objecting to ignorance he applies his objections mainly to the conceit of the operator; and, in the second place, that he excludes from general surgery what it appears is possibly inappropriate in abdominal surgery.

Dr. W. L. Rodman, Louisville: I thought, as I listened to the paper of Dr. Cecil, that I had never heard a better one or one more to the point. I think that the applause with which the paper met indicates that there is quite the same feeling among a large number of gentlemen here, who are tired of being called surgical tinkers by a few prominent gynecologists in the country because they do not send all their cases to them to undergo abdominal section or other important operation. There is a lot of gentlemen in Philadelphia who apply that word in a very general way. Everybody is a surgical tinker who can not do one hundred and seventy-five laparotomies and hysterectomies in a month. I think, if we had more papers of this kind, that real, true, substantial gynecology would advance far more rapidly than now.

I was struck with so many things in Dr. Cecil's paper that I hardly know where to begin to discuss them. I was first struck with the point that it would require far more moral courage for a surgeon to replace a healthy ovary after opening the cavity than to remove it. I have seen it removed time and again, and so has Dr. Cecil, and so doubtless have those gentlemen who have just spoken. It is time to call a halt in these cases. Dr. Cecil also speaks of the fact that some of these gentlemen would refer every case of uterine fibroid to the knife. They are condemned to the knife when they are not bigger than the fist. Everybody knows that their removal by this means is one of the most serious operations in surgery, and everybody with an elementary knowledge knows that a fibroid tumor never killed anybody anywhere, except in a few cases, possibly, where it caused twisting of the gut or incessant vomiting, as in the case of very large tumors. Nothing is more benign or innocent than a fibroid, and no operation is more serious than hysterectomy done for its relief. Homans, of Boston, undoubt-

edly takes the proper position in these cases, and he has seen more fibroids than anybody in America. After reporting many hundreds of these cases, in a paper read before the last meeting of the American Surgical Association, he stated as his conviction, borne out by years of experience, that but one in ten should be condemned to the knife. Now, when a man of Dr. Homans' great ability talks in this way, and says he is not willing to operate on more than one in ten, what are men to say and do who have very much less experience than he has. All honor to gynecology, and especially to American gynecology, which is to-day leading the world and has been in the lead for many years; but surgeons in this department are undoubtedly going too far when in innocent troubles they attempt relief by a serious operation which has, perhaps, a mortality of twenty-five per cent in the very best hands.

While I believe that much has been done by antiseptics, that is, the use of chemical agents to obtain chemical cleanliness, I must concede, with Dr. Cecil, that the tendency in surgery to-day is undoubtedly in the direction of asepsis rather than antisepsis. I think Dr. Cecil was misunderstood; I do not think he intended to say that chemical antiseptics did not have a distinct field in surgery. But I understood him to mean that in ordinary, fresh, surgically clean wounds these chemical agents were not proper. I believe more women have been killed by having bichloride of mercury poured into the abdominal cavity in the strength of 1 to 500 than have ever been benefited by it. No one now ever uses it in the abdominal cavity, and that is the best proof of the fact that a great many people have been killed by it. It has no longer any place in abdominal practice. I think Dr. Cecil is quite willing to admit that in the cases that Dr. Grant speaks of, cases that we recognize as essentially septic and full of germs, the use of bichloride of mercury or some one of the chemical agents is proper, just as Dr. Grant claims. He simply meant that the trend was in favor of asepsis rather than antisepsis. Another point well taken in the paper is that morphia is used too liberally in these cases.

Dr. M. F. Coomes, Louisville: I arise to commend Dr. Cecil for one thing if for no other. I was very much charmed with his excellent paper, and with Dr. Rodman I think he was misunderstood. I inferred from Dr. Cecil's paper this much, that if we would all report our mistakes, in other words, make the report of unfavorable cases as accurately and as fully in detail as we do favorable cases, medicine and surgery would advance much more rapidly than now. The cases that result unfavorably we can always learn important lessons from, but not so often can we learn such lessons from the cases that result favorably. A surgeon's report, thus, "In my last seventy-five unfavorable cases I had such and such results," would be odd reading, but it would stand for substantial progress in surgery.

Dr. J. G. Cecil: I would rather be damned by faint praise than be passed by unnoticed. I was surprised, however, at the position taken by my friend, Dr. Mathews; he must have misunderstood me, certainly, in regard

to exploratory incision. The point I wish to make is, that I believe that this is not a dangerous procedure in the hands of careful men with the ordinary surroundings of clean surgery. I said that it was a very necessary procedure; but I said that it ought not to be resorted to until all other and more exhaustive and less heroic methods had been pursued. I further made this comment, that I believed it had been sadly abused by good operators, and by men who were seeking for something of which there was vague evidence; having perhaps exhausted every avenue of investigation they had recourse to this as the last resort. This is proper, and I do not object to it. I said that the abuse came in this way: that tubes and ovaries are sacrificed when there was no evidence of disease in them. I have seen that done all the way from New York to Louisville. I have seen it done by the best operators. I have seen the exploratory incision abused in the same way, and I make that point against the practice. I do think it is more courageous and evidence of better surgery for a man to pull up an ovary after an incision, investigate it, and if it is not diseased put it back, than it is to cut it out, thus spaying the woman for no good whatever. Let us suppose a patient has been suffering from dysmenorrhea for two or three years: you make an examination, employ every means of diagnosis, and yet you are not satisfied; then an exploratory incision as a last resort may be justifiable. But when this is made, proceed no further if you do not find disease. No man has more regard for gynecology than I. If the surgeon finds a pus-tube or ovary diseased, let him cut it out. Relief is speedy in such cases. But cyclical and monthly troubles are not relieved by cutting out healthy tubes and ovaries. The right of exploratory incision is sadly abused when healthy tubes and ovaries are sacrificed to the operator's desire to carry away some trophy of the operation. I do not think that good operators (I do not speak of tyros, men who have had an experience of four or five operations) have yet learned the lesson as to the pathological conditions which require operative procedure. I say this because I have seen the very best operators in this country cut out ovaries which I am satisfied were not diseased. The sacrificing of the ovary alone is bad enough; but this is not all, the woman is subjected to a dangerous procedure, and death is not unfrequently the result.

In regard to antiseptics I do not know whether I was misunderstood. I believe in antiseptics, but I said that the trend of opinion was rather in favor of absolute cleanliness. How do these gentlemen sterilize their instruments? Do they go now to solutions of boracic acid? No. What do they use? They wash them clean with soap and water, put them in a boiler or sterilizer and steam them for half an hour, and then they are considered clean, and they are kept clean by covering them until the operation. What is the history of antiseptics? Do you remember the time when we all glorified carbolic acid. Who uses it now? You remember the time when we used sprays. Who uses sprays now? The time is gone by now when bichloride of mercury is used in every wound. I do not believe that bichlo-

ride of mercury ought to be put into fresh wounds unless there is a very good indication for it in the shape of septic matter. I hold that bichloride of mercury has no place whatever in a clean abdominal wound. I do not believe that it should be used on any fresh surface that is not contaminated by septic material. It has been shown that bichloride of mercury produces necrosis of tissue which is inimical to the prompt and speedy healing of fresh wounds. Bichloride of mercury is the king of antiseptics. It can not be denied that it has its field, but this field is not to be found in clean surgical wounds made under the best provisions for asepsis. There are many other agents of the antiseptic kind which have their place and uses, but it can not be disputed that the best class of operators, surgeons, and gynecologists to-day trust to strict and rigid cleanliness rather than to chemical antiseptics, which often give false security, as shown by untoward results.

The Report on Surgery was read by Dr. M. T. Scott, of Lexington. Dr. M. F. Coomes read a paper on the subject of Nasal Surgery. No discussion followed the reading of these papers. They will appear in full text in an early issue of the American Practitioner and News.

Dr. R. B. Gilbert, of Louisville, introduced the following resolution:

Resolved, That it is the wish of the Kentucky State Medical Society that the legislature shall immediately pass the bill now pending before it known as an Act to Promote the Study of Anatomy and Surgery, which provides for the giving of unclaimed dead paupers' bodies to the medical colleges in the State for dissection.

Motion seconded and unanimously adopted.

The following resolution was also introduced:

Resolved, That the Secretary of the Kentucky State Medical Society be requested to notify the legislature of Kentucky at once of the foregoing resolution.

Motion seconded and unanimously adopted.

The Committee on Credentials reported a long list of new names for membership. On motion the proposed members were elected by the casting of one ballot by the secretary.

FIRST DAY—EVENING SESSION.

Wednesday, May, 1883, 8 P. M. The session was called to order at the Opera-house. The president, Archibald Dixon, M. D., of Henderson, read the annual address.

Dr. Dixon said:

* * * * *

The Kentucky State Medical Society has had a glorious past, and can look forward to a still more glorious and useful future. Few of us appreciate its value and the immense advantage it has been to the medical profession throughout the State. Its annual meetings have improved the morals, fostered the devotion to scientific investigation, and engendered a mutual respect and good feeling between its members.

* * * * *

The science of medicine has been so much enlarged in all its different departments by the minute researches now demanded, and by the great and rapid progress of many of its specialties, as to require that every moment of one's time be occupied in the closest study in order to keep abreast with the daily advances in our profession. And he who is thus engaged has no time to study the defects of others. Let us put all this behind us, and, in the language of a distinguished medical editor, "Let us try to be neither dead nor dull, but let us be saturated with a desire to improve, advance and inspire each other to do the best work in our power for humanity and the profession. Let us strive to make the uppermost thoughts of our lives those connected with science, humanity, charity, business thrift, brotherly kindness, and cheerfulness." That we have advanced, and that Kentucky medicine is fully abreast with the age, there can be no doubt; and as convincing evidence of this fact one has only to turn to the report made by your Publication Committee of last year's proceedings—a volume of transactions filled with strong, sensible, practical papers, most ably edited, well printed, and well bound; in fact a volume which would reflect credit upon the American Medical Association itself. I can pay no higher compliment to your Committee on Publication than to suggest that it be continued without change.

In matters pertaining to the public health and sanitation it may be said, without the fear of contradiction, that Kentucky is keeping step with her sisters. With the limited fund provided for her Board of Health—about the smallest in the Union—and with the county boards doing their work gratuitously, the success attained by her State Board, while it may not be up to its expectations and desires, compares favorably with that of other States even where the provision for carrying on the reform has been much more liberal. Boards of health exist in every county in the State, some quite active, many ordinarily dormant, but all with the machinery organized to deal with local epidemics of any character, such as smallpox, diphtheria, scarlet fever or spotted fever, like those occurring recently in the counties of Webster and Butler. Such outbreaks are managed with little interference to commerce and travel, and usually at a nominal cost to the county or municipality, in striking contrast with the panics and extravagances of times antedating the existence of health boards. In most of our cities and towns, and in thousands of private families, sanitary knowledge is being applied in the management of their affairs with the most satisfactory results,

and the sentiment to which this is due, both professional and personal, is of steady growth; and with the continued education of the people in this regard it will be found, as it already has, that legislation in so far as the public health is concerned is easier to obtain and in fact becoming recognized as a necessary and most important branch of State government. To our own State Board is largely due the origin of the "International Conference of State and Provincial Boards of Health," by whose work it is confidently believed that every agency available under State and National laws has been co-ordinated and utilized for excluding cholera from our shores, and in providing the machinery for an efficient inspection service at every threatened point, ready to be set in motion at a moment's notice, should the disease break through at any weak spot in our line of quarantine defenses. These plans are broad and comprehensive, beginning with the immigrant and his effects from the place of his departure in Europe and following him to his final destination in this country, step by step, constituting a safeguard which may be relied upon either to prevent or at least mitigate the horrors of an epidemic.

The report of the sanitary survey in Louisville, in the face of the bitter criticism to which our State Board of Health, and especially its secretary, Dr. McCormack, was subjected last year, is a most complete triumph, and the results can not but be far-reaching for good both there and elsewhere. The new practice act recently approved by the Governor is a great advance on the old law under which, by vigorous prosecutions and the aid of a united profession in the city of Louisville and throughout the State, much good work was done. The new law is substantially the one now in force in Illinois and Minnesota, and if it has the strong support to which it is entitled the day of the quack doctor in Kentucky will soon be over. I can not urge upon the members of this Society and the profession at large too strongly the importance of supporting the member of the Board of Health in their endeavors to ward off death and disease from our State. They have done and are doing good work, and I may say, with the limited means at their disposal, work which compares favorably with that done in States with appropriations much larger.* "The serious objections made by legislators to health reform is that it is expensive, and that such boards as ours are especially open to this objection during the formative period of their work. That this objection disappears as the work progresses is shown by the experience of England, where in half a century it has cut down the death-rate from thirty-two to eighteen per thousand, and has become one of the most popular and best supported branches of the government; and in Michigan, where an appropriation of \$30,000 was made last year to establish a laboratory for hygienic work, in addition to the \$16,145 provided for the annual support of the board."

In order to show how Kentucky stands in the matter of revenue for general and special public health uses and prevention of epidemics, the fol-

* Report of State Board of Health.

lowing table, taken from the last report of the State Board of Health of Kentucky, is given:

A graduated list, showing the total amounts of appropriated revenue available in the year 1888 for general and special public health uses and prevention of epidemics by the various State Boards of Health in the United States.

| | | | |
|------------------------------|-----------|---------------------------|---------|
| Massachusetts, | \$111,300 | North Carolina, | \$5,500 |
| Louisiana (about), | 100,000 | Indiana, | 5,000 |
| Texas, | 61,000 | Iowa, | 5,000 |
| Illinois, | 49,000 | Pennsylvania, | 5,000 |
| Mississippi, | 46,550 | Maine, | 5,000 |
| Minnesota, | 29,000 | Kansas, | 4,500 |
| New York, | 25,000 | Ohio, | 4,500 |
| New Jersey, | 21,500 | South Carolina, | 4,000 |
| Wisconsin, | 20,500 | Tennessee, | 3,000 |
| Michigan, | 16,145 | Rhode Island, | 2,700 |
| Alabama, | 13,000 | Kentucky, | 2,500 |
| Maryland, | 13,000 | Vermont, | 2,500 |
| California, | 12,500 | West Virginia, | 2,000 |
| Connecticut, | 10,000 | Delaware, | 350 |
| New Hampshire, | 8,500 | | |

It will be seen that Kentucky has the princely sum of \$2,500 at the disposal of her health board for the purposes set forth above. Scarcely a sufficient sum to put in sanitary condition one of her smaller cities. 'T is true that the present legislature has appropriated \$10,000 to be used in case of emergency and at the discretion of the Governor. In view of the threatened invasion of cholera it would not be out of place for this Society to ask of the legislature to turn over this amount to the State Board of Health to be used in protecting our people in their health.* "The State can make no other investment which will pay so large a dividend." The wealth of Kentucky lies as much in the health of her sons and daughters as in her fertile fields, fine herds or rich mines, yet thousands die or lose health every year from diseases which can and ought to be prevented. The heaviest tax which falls on any State, city, or county under our modern civilization is that caused by the unnecessary sickness and death of its citizens, and this tax it is certainly the province of the State to diminish or prevent. "If it is important to invite immigration to our State, is it not at least equally important to attempt to preserve the health and lives of our own people already here?" From a simple commercial point of view, should a single case of cholera appear in Louisville during this year, it would be a financial calamity in comparison with which the expenditure of \$10,000 or \$50,000 as a prophylactic would be trivial. And this calamity would not only affect Louisville, but the entire State as well. When with the advent of warmer weather the conditions of travel and of germ-development become more favorable, all the possible rigors of quarantine can hardly prevent sporadic cases at

*Report State Board.

least arising within our borders, and every means of preventing the danger should be well provided for in advance. Our State Board of Health stands ready to do all this, but can it be done without adequate means? Medicine now calls upon the people and warns that there must be a municipal and general house-cleaning, that, despite all quarantine, the possible epidemic is probable, and that at least the only safety lies in internal health and sanitation, in an ability to deal with cases of cholera wherever and whenever they may occur. This ability can not exist without a purified water supply, clean cities, and an everywhere existing machinery of local medical policing, that, to speak plainly, nowhere exists. The care of the public health must be taken out of the hands of ward politicians and put into the keeping of men who are fitted by study, by experience, and by morality to solve the tremendous problems of the prevention and cure of disease. The mechanisms and methods of such solutions must be permanent; they can not be created in a few days by a panic-stricken populace or by *bouffe* politicians, but they are the products only of many years of virile and conscientious intelligence. When the present danger has passed the permanent danger of the future will then be present.

Attorney-General W. J. Hendrick and Col. E. Polk Johnson, of Frankfort, delivered appropriate addresses.

[TO BE CONTINUED.]

PAN-AMERICAN MEDICAL CONGRESS.—The Section in Marine Hygiene and Quarantine has been organized as follows: Dr. Lino Alarco, Lima, Peru; Dr. Henry B. Baker, Lansing, Mich.; Dr. Cardenas, Managua, Nicaragua; Dr. J. J. Cornilliac, St. Pierre, Martinique. F. W. I.; Dr. Felix Formento, New Orleans; Dr. H. B. Holbeck, Charleston; Lieutenant-Colonel Amalio Lorenz, Sub-inspector of second class Spanish Navy, Havana; Dr. F. Montizambert, Quebec, Canada; Dr. Francisco Nunez, St. Tecla, Salvador; Dr. Juan Ortego, Guatemala, Guatemala; Dr. Joseph Y. Porter, Jacksonville, Fla.; Dr. John Pringle, Kingston, Jamaica; Dr. Juan J. Unoa, San Jose, Costa Rica; Dr. J. Mills Browne, Surgeon General, United States Navy. Executive president: Dr. Walter Wyman, Surgeon General, United States Marine-Hospital Service, Washington. Secretaries: Dr. S. T. Armstrong (English-speaking), 166 West Fifty-fourth Street, New York; Dr. G. M. Guiteras (Spanish-speaking), United States Marine-Hospital Service, Washington. Advisory Council: Dr. H. M. Biggs, New York City; Dr. John C. Boyd, United States Navy; Dr. H. R. Carter, Norfolk, Va.; Dr. W. M. L. Coplin, Philadelphia; Dr. A. G. Clopton, Galveston, Texas; Dr. C. G. Currier, New York; Dr. S. Durgin, Boston; Dr. Seneca Egbert, Philadel-

phia; Dr. George Homans, St. Louis; Dr. W. T. Jenkins, New York; Dr. J. F. McShane, Baltimore; Dr. G. H. F. Nuttall, Baltimore; Dr. S. R. Olliphant, New Orleans; Dr. Dabney Scales, Mobile, Dr. R. M. Sweringen, Austin, Texas.

The executive president desires to call the attention of all members of the medical profession that are interested in the topics pertaining to this section to the regulation of the congress, that contributors are required to forward, not later than July 1st, to the secretary of the section, abstracts, not to exceed six hundred words each, of the papers they propose to present before the section.

The topics that will be considered by this section are as follows: The hygiene of vessels, commercial or naval, including the questions of ventilation, heating, sanitary arrangements, the disposal of cargo so as to facilitate disinfection, food supply, etc. (2) The medical officers of passenger vessels; methods for their selection, duties, etc. (3) The vital statistics of seamen and firemen. The question of the medical examination of crews preparatory to shipping. (4) The supervision of vessels by government medical inspectors at ports of arrival and of departure. Code of rules for handling an epidemic disease that breaks out on shipboard. Disinfection of passengers and crew during a voyage. Location and arrangement of ship's hospitals. (5) Epidemic and exotic diseases propagated by shipping. What diseases should be quarantined. Responsibility of nations for epidemics: India for cholera, South America for yellow fever. Can a feasible plan be devised to totally exterminate cholera? International intervention to prevent the propagation of cholera or other epidemic diseases by pilgrimages or immigration. (6) International uniformity in quarantine regulations. Should quarantine officers be notaries public? (7) Arrangement of detail and equipment of quarantine stations: *a*, inspection of stations; *b*, local quarantine stations; *c*, refuge stations. Methods for handling infected or suspected vessels. Interstate and inland quarantine: sanitary cordons; camps of refuge; camps of probation. Recent improvements in hospitals for infectious diseases. Railroad inspection and quarantine. Length of time vessels should be held in quarantine. Conditions that should determine proclamation of quarantine against a country. Under what requirements may passenger traffic be carried on between a port infected with yellow fever and a southern port of the United States during the summer with the least obstruction to such traffic? What merchandise should be considered as requiring treatment if shipped from a port or place infected with cholera, yellow fever, smallpox? (8) Methods of disinfection: *a*, persons; *b*, baggage; *c*, cargo; *d*, vessels. Recent improvements in quarantine appliances: steam chambers; sulphur furnaces. Liquid sulphur dioxide as a disinfectant. Treatment of ballast: water; solid. What time should an infected vessel be detained in quarantine?: *a*, for cholera; *b*, for smallpox; *c*, for typhus fever; *d*, for plague; *e*, for yellow fever. Methods of disposal of the bodies of those that die while in quarantine.

Reviews and Bibliography.

Hand-book of the Diagnosis and Treatment of Diseases of the Throat, Nose, and Naso-Pharynx. By CARL SEILER, M. D., Instructor in Laryngology and Lecturer on Diseases of the Upper-Air Passages in the University of Pennsylvania, Chief of the Throat Dispensary at the University Hospital, Physician-in-Chief of the Union Dispensary, etc. Fourth edition, thoroughly revised and greatly enlarged. Illustrated with two lithographic plates containing ten figures, and one hundred and seven wood engravings. Philadelphia: Lea Brothers & Co. 1893.

We are pleased to note the reappearance of this little work. Much of the original text appears in this edition, but the author has added several new chapters, and the scope of the work is enlarged. The author thoroughly describes the technique of the various examinations of the nose and throat. His illustrations of instruments, many of which are modifications of the original ones by the author, and their methods of use, are good, and render the work doubly valuable.

The colored plates in the beginning of the work are true pictures of the conditions represented. On page 29 is described an electric illuminator for the laryngoscope originated by the author. The "record sheet," page 98, will serve as a valuable aid to the specialist.

In the therapeutics of the mucous membrane the author rightly gives prominence to the local use of strong solutions of silver nitrate, not less than "forty, sixty, eighty, or even one hundred and twenty grains to the ounce of water, with or without glycerine." He limits its use to the acute affections, and states that "in the subacute and chronic inflammations attended with hypertrophic conditions of the glandular and submucous tissue nitrate of silver is harmful."

The subject of Hypertrophy of the Uvula and Tonsil is interestingly treated, but perhaps not sufficient is said upon the importance of cutting off the hypertrophied tonsil as close to the pillars as possible, especially in children, in whom this condition is a constant source of trouble.

Mathieu's tonsillotome has always seemed to the reviewer to be a too complicated instrument, the author's modification of it not affecting its mechanism.

Vanillin in the proportion of ten grains to one gram of iodoform has been found by the author to disguise the odor of that drug "to a very great extent, if not entirely."

Under the caption of Uterine Reflex Laryngitis is described an interesting condition of the "mucous membrane in the upper air-passages which is neither an anemia nor a congestion, and yet is abnormal, and this pathological condition I have found to be invariably caused by a pathological condition of the pelvic organs of the female, and so certain and distinct is

this evidence of uterine disease in the upper air-passages that the laryngologist can diagnose the presence of uterine trouble merely by the inspection of the larynx and pharynx." Then the author goes on to give the results of a series of recorded cases in which the diagnosis of pelvic disease was made in this manner, and in which either before or subsequently a similar diagnosis was made by a vaginal examination by Prof. Howard A. Kelly, of the Johns Hopkins University. An acquaintance with this condition will serve as a valuable aid to the physical diagnostician who is consulted in regard to the treatment of the subjective symptoms, which, as stated by the author, may be associated with this condition.

But a single mention is made of intubation in this work. It is our opinion that it is always indicated in cases of catarrhal laryngitis with associated spasm, and in certain cases of stenosis of the larynx it can be used advantageously and worn for some time without injury.

Influenza and The American Grippe are the subjects of an interesting chapter in which he contrasts and differentiates the two diseases. The latter he designates as myxoidedema epidemica, with the popular synonym of the American grippe. Its description and treatment are largely the same as embodied in a paper read by the author before the American Medical Association in December, 1889. The appended table of symptoms is a thorough one, and of use to the student.

The volume is thoroughly indexed, and the work gives evidence of being written by an observer of large experience. H. E. T.

Psychopathia Sexualis, with Especial Reference to Contrary Sexual Instinct: A Medico-Legal Study. By DR. R. VON KRAFT-EBING, Professor of Psychiatry and Neurology, University of Vienna, authorized translation of the seventh enlarged and revised German edition, by CHARLES GILBERT CHADDOCK, M. D., Professor of Nervous and Mental Diseases, Marion-Sims College of Medicine, St. Louis, etc. In one royal octavo volume. 436 pp.; extra cloth, \$3; sheep, \$4. Sold only by subscription. Philadelphia: The F. A. Davis Publishing Company. 1893.

It is unfortunate that it is incumbent on any one to become acquainted with the dark and humiliating side of human nature revealed in the work before us, but for many reasons it does become philosophers and scientists to know every departure from the normal that afflicts any, even the most humble of our race. It allows one a better opinion of his kind, a more satisfactory opinion of himself, to learn that acts that seem degrading beyond all qualification are due to inborn perverseness, and that these accidents of organization to a very large extent excuse the individual and remove from the race what would otherwise be an overshadowing odium.

The author has here gone over the entire field of sexual perversion, and what with examples of other works on the theme, and what with his own large experience, has thrown light into every dark corner of his subject. First treating of the psychology and physiology of normal sexual life, the author then takes up the general pathology, and pursues it into all its special applications, such as sadism or overpowering sexuality with violence to

the object toward which it is directed, masochism or controlling sexuality with the inclination to slavery to the object of it; fetichism, where the sexual impulses are developed or strengthened by ideas of clothing, etc., belonging to persons of the opposite sex, and then the numerous cases of homo-sexuality, where the desire is to an individual of the same sex.

For treatment, where treatment gives promise of success, which is in only a small percentage of cases, the author relies almost wholly on hypnotic suggestion. The author makes a plea for greater charity of the law toward those who suffer from sexual perversion, and shows how it is that in countries where there are no laws, especially against uriningism, society gets along as well and with fewer offenses connected with the perversion than where attempted restraint adds the opportunity of blackmail to other crimes.

After all, as intimated already, one turns sadly from this history of human depravity. It may be a relief to know that all these perversions are but eruptions from the strata that underlie the fair fabric of humanity, but the relief is far from complete when we reflect how perilously near the surface these defiling strata lie. After such studies one inclines to contemplate an existence wherein the needs of sordid gain, even the requirements of dress and food and all the promptings and impulses connected with race perpetuation are done away in the dreamy Nirvana.

D. T. S.

A Practical Treatise on Materia Medica and Therapeutics, with Especial Reference to the Clinical Application of Drugs. By JOHN V. SHOEMAKER, A. M., M. D., Professor of Materia Medica, Pharmacology, Therapeutics, and Clinical Professor of Diseases of the Skin, in the Medico-Chirurgical College of Philadelphia, etc. Second edition, revised. In two royal octavo volumes. Volume 1, 353 pp., devoted to Pharmacy, General Pharmacology and Therapeutics, and Remedial Agents not Properly Classed with Drugs; Volume 2, 680 pp.; an Independent Volume upon Drugs. Volume 1, cloth, \$2.50; sheep, \$3.25. Volume 2, cloth, \$3.50; sheep, \$4.50. Philadelphia: The F. A. Davis Company. 1893.

While it is hardly to be denied that there is just now no crying need for an addition to our list of therapeutic text-books of the same general character as those we already have, it must yet be admitted that this work is entitled to rank with those already most in vogue. The author has done very little in the way of original investigation, but he has made a judicious use of the investigations and studies of others. Indeed one is hardly expected to give us much out of his own original research, seeing years of study, even under the most favorable conditions, are required for the complete study of any given drug.

The views expressed on all points in controversy must impress the reader as judicially fair and conservative, albeit the time has not yet come for an author who expects sale for his book to label "trash" on hundreds of articles that never encumber the pages of works on therapeutics. We predict for this work in its new dress the success that the author's industry, energy, and ambition, as well as his acknowledged talents, entitle it to.

D. T. S.

The International Medical Annual and Practitioner's Index for 1893. Edited by a corps of thirty-eight department editors, European and American, specialists in their several departments. P. W. WILLIAMS, M. D., Secretary of Staff. 626 octavo pages. Illustrated. Price \$2.75. New York: E. B. Treat, Publisher, 5 Cooper Union.

The eleventh yearly issue of this valuable one-volume reference work is at hand, and it richly deserves and perpetuates the enviable reputation which its predecessors have made for selection of material, accuracy of statement, and great usefulness. The corps of department editors is representative in every respect. Numerous illustrations, many of which are in colors, make the Annual more than ever welcome to the profession, as providing at a reasonable outlay the handiest and best resume of medical progress yet offered.

Part I comprises the new remedies, together with an extended review of the therapeutic progress of the year.

Part II, comprising the major portion of the book, is given to the consideration of new treatment, and is a retrospect of the year's work, with several original articles by eminent authorities.

The third and last part is made up of miscellaneous articles, such as Recent Advances in Sanitary Science, Improvements in Pharmacy, New Inventions in Instruments and Appliances, Books of the Year, etc.

The arrangement of the work is alphabetical, and with its complete index makes it a reference book of rare worth.

In short, the Annual is what it claims to be, a recapitulation of the year's progress in medicine, serving to keep the practitioner abreast of the times with reference to the medical literature of the world.

Text-book of Ophthalmology. By DR. ERNEST FUCHS, Professor of Ophthalmology in the University of Vienna. Authorized translation from the second enlarged and improved German edition. By A. DUANE, M. D., Assistant Surgeon Ophthalmic and Aural Institute, New York. With numerous illustrations. 788 pp. New York: D. Appleton & Co. 1892.

In the multitude of books that teem from the medical press there now and then appears one that claims the rank and station of a classic. Such an one is this text-book of ophthalmology. The author is evidently not only a master in his special department, but also an artist in setting forth his knowledge. He is especially happy in presenting illustrations of principles drawn from the field of physics. The work throughout is marked by a judicious selection and careful presentation of facts and a completeness and freshness of information that have justly won for it the high place it holds among ophthalmological text-books. How much of its clear, concise, and pleasing style may be due to the translator, and how much to the author, might perhaps be known only by comparison with the original, but certain it is that in these qualities it has few superiors. The lucidity of the work makes one overlook the difficulties of the subject-matter, and tempts one to its study as a pleasant recreation.

D. T. S.

Medical Consultation Book: A Pharmacological and Clinical Book of Reference, containing the Therapeutics of a Full List of the Official and Non-Official Articles of the *Materia Medica*, with a Consideration of the Action of Medicine, including an Extensive Collection of Favorite Prescriptions from the Most Reliable Authorities of the Medical Profession, so Classified as to be of Ready Access for Authenticated Treatment of each Disease in its Different Stages and Complications, etc. Designed for the Consultation Room. 776 pp. Austin, Texas: Eugene von Beckman, Printer. 1893.

The scope of this work is so fully set forth in the title as to leave little to be said by the reviewer in that regard. It is an industrious and judicious selection of prescriptions and matter relating to prescribing from nearly every author of note. It might be not inaptly called a prescriber's encyclopedia.

While we think that the physician, in beginning, ought to make a rational study of the powers of every remedy used, and their effects in combination, so as to be able to combine them all into indefinite numbers of appropriate prescriptions, it must be conceded that as an auxiliary the ready-made prescriptions of acknowledged authorities may often be adopted in emergencies before we have time by appropriate study to make them our own. Furthermore, there is found now and then a physician who practices medicine as some musicians practice their art, by ear. To such doctors an assortment of ready-made prescriptions is indispensable. Whatever the circumstances may be, one can hardly desire a more complete assortment than is here presented.

An innovation of the author that may hereafter be developed into a very valuable feature of therapeutics is an endeavor to express numerically the relative forces or powers of the various drugs. Since some physicians, however, will persist in placing at zero drugs whose curative powers others would place at a full hundred, it is to be feared it will be a long time before any thing helpful can be developed along this line.

D. T. S.

The Students Quiz Series: Diseases of the Skin. A Manual for Students and Practitioners. By CHARLES D. RANSOM, M. D. Series edited by Bernard B. Gallaudet, M. D. 201 pp. Price \$1. Philadelphia: Lea Brothers & Co.

This is one of the most attractive of the many publications of its class that has yet appeared. One can hardly fail to be a little surprised at the list of authorities given by the author in his preface; but as the inadequacy of the bibliography does not affect the work in hand it may be passed over without criticism.

D. T. S.

Transactions of the American Orthopedic Association, Sixth Session, held at New York City September 20, 21, and 22, 1892. Volume 5. Philadelphia: Published by the Association.

This volume is as attractive as its predecessors, and contains a list of its officers, presidents, and members, with the minutes of the sixth annual meeting. It contains all but six of the papers presented before the Association, with full and interesting discussions reported. It is neatly bound and well illustrated.

H. E. T.

Abstracts and Selections.

ON THE PYROZONES.—This name is given to a series of preparations of peroxide of hydrogen which offers the great advantages of being very stable and of exact chemical strength.

It is well known that the ordinary so-called "fifteen-volume" solutions in the market never have contained fifteen volumes by correct assay, and sometimes differ as much as fifty per cent in strength, even when fresh.

Part of this great difference, no doubt, occurs in the manufacture, but some of it has been due to a misunderstanding as to what a "fifteen volume" solution should be, and it is very probable that many physicians have only the most remote idea as to what such a solution is, in consequence of the unofficial and incorrect tests formerly suggested. This question has been set at rest by the manufacturers of pyrozone, who have supplied the medical profession with solutions of the H_2O_2 of exact percentage strengths.

There are three preparations of pyrozone, of different strengths and properties, and distinguished by different names. The first is the medicinal pyrozone, containing three per cent of absolute H_2O_2 , and can be used both internally and externally. One observer says it acts more rapidly on pus than the usual solutions, but there is such a great difference between the ordinary solutions themselves that it is very difficult to decide on such a question. The medicinal pyrozone retains its virtue permanently.

The second preparation is known as "antiseptic pyrozone," and contains five per cent of the absolute H_2O_2 in ether. It replaces the medicinal or three-per-cent solution where a stronger antiseptic is desired, and may be used as spray or applied locally. The third preparation is the "caustic pyrozone," so called on account of its action on organic matter. It contains twenty-five per cent of the absolute H_2O_2 . It has some interesting properties: When a drop is placed on the sound skin of the hand it causes the integument to assume a marble whiteness resembling that produced by carbolic acid. There is a slight sensation of smarting, after which the skin gradually resumes its normal appearance.

Drs. Ohmann-Dumesnil and Atkinson have used caustic pyrozone with good effects. The former finds it a valuable caustic in ulcerations.

THE VIABILITY OF THE CHOLERA BACILLUS ON VARIOUS FOOD-STUFFS, ETC.—Uffelmann, in a recent number of the *Berliner Klinische Wochenschrift* (1892, No. 48), records the results of an interesting investigation of the viability of the cholera bacillus on various food-stuffs and other necessities of life, made with a view to gaining some definite infor-

mation as to the danger of transport of the germs upon these substances. The experiments test the viability of the bacilli in water and milk, on bread, in butter, on meat, fish, vegetables, and fruits of various kinds, on paper, on coin, on both moist and dry clothing, and on his own skin. The possibility of the transport of the contagium by flies is also investigated.

Material from two cholera stools, both shown to contain large numbers of comma bacilli, was mixed with or spread upon these various substances, and inoculations of nutrient media were made at short intervals from the contaminated areas. In water the bacilli remained viable for from five to six days; in milk, for about three days; on the surface of bread exposed to the air, for about a day; between slices of bread kept more or less moist, for eight days; in butter, for three days; on cooked meat kept moist, for eight days; on apple and cauliflower, for four days; on paper, for about a day and a half; on copper and silver coins, for only ten minutes after thorough drying; on dry clothing, for four days, but on moist linen for twelve days or even longer. It was shown that for two hours after walking through cholera dejecta house flies were capable of infecting nutrient media, and that the dry skin of the hand preserved the germs alive for somewhat more than an hour after contamination.

These results are of much practical interest, as showing the length of time during which contaminated food stuffs may continue to be infectious. They also teach that the organic acids of milk, meat, fruits, butter, and sour bread do not cause immediate destruction of the cholera bacilli, and that the duration of their viability bears a general relation to the degree of moisture in the contaminated substance.—*The American Journal Medical Sciences.*

MILKY ASCITES.—Drs. Nieuwondt and Rozenzweig read before the Cape of Good Hope Branch of the British Medical Association a paper on a case of ascites in which a milk-like fluid was found. A thin and weakly child of fifteen months was suffering from diarrhea and vomiting on May 24th. By May 30th she had recovered, but on June 10th she became restless and seemed to be in pain. The abdomen was distended with tympanites and very tender, the pulse rapid and wiry, temperature above normal. Under treatment the abdomen had become all but normal on June 16th. The symptoms recurred, and chronic peritonitis with subacute exacerbations, possibly tabes mesenterica, was diagnosed. About September 1st the fluid had risen well above the umbilicus, the pulse was intermittent, and the child cyanosed. Aspiration was performed, and twenty ounces of white, milky fluid were drawn off. Aspiration was subsequently several times resorted to. During two months she was operated on eleven times, and six hundred and eighty ounces of fluid were taken from her. The fluid had the appearance of rich creamy milk, of specific gravity 1022. It did not coagulate spontaneously on standing. It contained a large amount of albumen and fat. Under the microscope it showed a granular basis, with

large nucleated cells here and there. The treatment mainly consisted in inunction of the abdomen with mercurial ointment and extract of belladonna equal in parts, rags dipped in cod-liver oil being laid over the abdomen whenever there was too much irritation to continue the ointment, and malt and cod-liver oil were given internally. After the last operation (November 5th) the child began to improve, and by January was quite as strong and healthy as before the commencement of the illness. Dr. Rozenweig thinks that the large amount of fat granules was due to the greatly increased degenerative action in the peritoneum.—*British Medical Journal*.

XANTHOMA DIABETICORUM.—Mr. Malcolm Morris and Mr. J. Jackson Clarke publish notes of a case of xanthoma diabeticorum. They consider that there can be no doubt that the affection is fundamentally of the same nature as the other conditions which have been grouped together under the general name of "xanthoma," excluding the xanthoma of Balzer. They sum up as follows certain clinical and anatomical points of difference between xanthoma and xanthoma diabeticorum. (1) While xanthoma (planum and multiplex) is slow in evolution, and generally permanent, xanthoma diabeticorum appears suddenly and subsides almost as suddenly. (2) Xanthoma planum invariably begins on the eyelids, and is usually confined to them; xanthoma multiplex affects chiefly the flexor and extensor surfaces of the limbs, the eyelids, and the palms; the diabetic variety for the most part attacks the neck, trunk, and extensor surfaces of the limbs. (3) Jaundice is a very frequent accompaniment of ordinary xanthoma in adults, and diabetes mellitus has never been recorded as occurring in association with it; the reverse is the case as regards xanthoma diabeticorum, in which saccharine urine is a constant feature, and jaundice is an unknown complication.—*British Journal of Dermatology*.

THE IODIDE OF STRONTIUM.—Dr. A. Malbec presents a very complete study of this remedy, which appears likely to obtain an assured position in therapeutics. It occurs crystallized in hexagonal tables, very soluble in water, and, when impure, readily decomposing into iodine and oxide of strontium, presenting various colors. Purity and stability are essential, as the iodate is toxic. As the potash salt, the iodide of strontium has a manifest action upon the heart, which can be utilized in affections of the myocardium, in changes at the aortic orifice and in the arteries. It certainly can be used as a substitute for the potash salt, although it may not always be preferred to it. Yet it does not, after prolonged usage, give rise so readily to intolerance, and it will be more readily accepted by a patient suffering from cardiac disease if he should know of the use of the potash salt as a specific for syphilis. It can be prescribed the same way as the potash salt, in the same dose in simple solution in distilled water, or, to avoid the salty taste, in the sweet liquors, or in syrup, or that of bitter orange-peel.—*Les Nouveaux Remèdes*, 1892.

THE AMERICAN PRACTITIONER AND NEWS.

"*NEC TENUI PENNĀ.*"

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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This journal is devoted solely to the advancement of medical science and the promotion of the interests of the whole profession. Essays, reports of cases, and correspondence upon subjects of professional interest are solicited. The editors are not responsible for the views of contributors.

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JOHN P. MORTON & COMPANY, Louisville, Ky.

THE STATE SOCIETY.

In consequence of difficulties known only to the editor, and surmountable only to this much-abused and overworked member of the guild medical, the first part of the transactions of the State Society could not be made to appear in an issue earlier than this, and this, to our sorrow, is behind time for the same reason. For these delays we bespeak the indulgence of our readers, and promise good time on the next issue, and those to follow.

The first installment of the transactions is up to the best work of the Fellows and fully warrants the high encomiums passed upon the State Capital meeting by the members on their return. Aside from the doing away of the formal committee reports on the year's progress in the different departments of medicine, there was little business of interest to the profession transacted. The alteration of a few defective articles in the Constitution, and the memorialization of the State legislature in the matter of making easier the getting of anatomical material for the medical schools represent about all that was done.

The proposed new departure contemplates the appointment of leaders who shall present and speakers who shall discuss certain medical problems selected for consideration by a committee elected for the purpose. Each leader will have the best part of a year for the study of his topic, and each respondent will have timely notice of the subject selected and the points to be made by the leader.

Under the old regime the "committee" too often gave us a few notes from practice, or a homily on some hobby of interest to no one but himself. Many admirable reports 't is true were made; but when so made those who might wish to discuss them found in them often nothing calling for comment, or were forced for lack of notes or time for the arrangement of their ideas to effuse in rambling talks which were of little or no interest to the hearer, and of less interest or worth in the published proceedings. The new departure will not only stimulate careful study on the part of the Fellows at home, but will insure a full, connected, well-digested, and scientific discussion at the sessions of the great problems in medicine. The advantages of the scheme are patent, and we trust the committee will lose no time in getting the Fellows started in the work for next meeting.

The place of meeting named for next year seems to be a stumbling-block in the way of securing a full attendance. To any member with a love for the beautiful in nature, and a taste for gastronomic solidities and refinements, the sublime mountains about the "boom city," and the great hotel in the same, ought to be attractions which, when added to the charms of the programme, would cause him to take no account of extra distance traveled and time consumed in getting to the thirty-ninth meeting and home again. But those who have the management of affairs in hand know best, and the motion to reconsider the resolution to meet in Middlesborough was perhaps not unwise.

Altogether it may be truthfully said that the record of the thirty-eighth annual meeting was such as every Fellow of the State Society may contemplate with the pride of a Kentuckian and a doctor.

THIS issue of *The American Practitioner and News* appears with sixteen additional pages, necessitated by the publication of the first day's proceedings of the State Society.

This journal is the organ of the State Society, and will publish a report of the transactions which omits nothing that may be of practical or scientific interest to our readers.

Every member of the Society, not now a subscriber, will receive this number complimentary. It is thus presented for two reasons: first, that the recipient may see what the journal is doing for the cause of

medicine in Kentucky, and, second, that we hope to secure him as a subscriber. We believe, when the merits of the journal are weighed side by side with its competitors, and its position as organ of the State Society and exponent of things medical in Kentucky is understood, that every member of the Society will be inclined to favor us with his subscription.

Notes and Queries.

EXPERIMENTS RELATIVE TO THE ETIOLOGY OF CHOLERA ASIATICA.—In the *Münchener Medicinische Wochenschrift* of November 15, 1892, Prof. Pettenkofer relates at length his experiments during the recent epidemic of cholera relative to the etiology of that disease. Pettenkofer is one of the few remaining adherents of the old theory of the meteorologic factor in the causation of infectious diseases, more particularly of those occurring in epidemics. The necessary factors in the etiology of these diseases he expresses by the formula, $x+y+z$ =infectious disease, in which x represents the specific micro-organism of the disease, y the climatic and local predisposing factors, and z the individual predisposition. Without the simultaneous occurrence of all of these he believes an epidemic impossible.

In the recent epidemic of cholera Munich escaped, and, as commerce and travel between that city and those in which the epidemic raged was unrestricted, Pettenkofer refuses to believe the escape of Munich to have been due to the non-transport of the comma bacilli to that city, and attributes it to the absence of certain atmospheric conditions necessary to the development of the disease. With a view to proving this he resolved to test upon himself the power of a virulent culture of the cholera germs to produce the disease. Animal experiments, he reasons, are misleading; the only reliable conclusions are deducible from inoculations in man.

Having obtained a fresh culture of the cholera bacilli from Gaffky in Hamburg, Pettenkofer prepared bouillon cultures from these. These bouillon cultures were shown by examination to contain very large numbers of the germs. On the morning of the 7th of October Pettenkofer swallowed one cubic centimeter of such a bouillon culture suspended in one hundred cubic centimeters of a one-per-cent solution of sodium carbonate, the object of which was to neutralize the acid of the gastric juice. No effect was noticed for about thirty hours, when diarrhea commenced, which lasted eight days, until the 16th of the month. The passages were at first of soft consistence only, and colored, but by the second day of the diarrhea they had become very watery and almost colorless. This continued until the morning of the 13th, when they again became colored and of thicker con-

sistence. On the morning of the 16th the passage was normal. During all this time there are said to have been no other symptoms except occasional painful desire to stool and a great deal of rumbling in the bowels. The appetite remained good, there was no nausea at any time, and the diet was unrestricted. Sleep was only a few times interrupted by desire to stool, and Pettenkofer continued the daily routine of his work as usual. He says that but for the diarrhea he should not have known that he was sick in any way. No treatment was used.

Examinations for the cholera bacilli were made by Drs. Pfeiffer and Eisenlohr. They were found in the watery stools in large numbers, but gradually disappeared as the passages became thicker, until on the 16th none could be detected.

Pettenkofer considers this sickness to have been nothing more than a moderately severe diarrhea, perhaps dependent upon a slight degree of enteritis.

The experiment was repeated on the 17th of October by Prof. Emmerich with similar result, though the symptoms in this case were more severe. Many of the stools were of a distinctly rice-water appearance, and they were much more frequent than in Pettenkofer's case. Prostration also was apparent, though the mind appears to have been cheerful. On October 24th the stools became formed, and were normal from that time. Comma bacilli were found in the stools from the 18th to the 28th; on the 19th in pure culture in the rice-water discharges.

Both of these cases were observed clinically by Profs. Bauer and Von Ziemssen, and were said by them to differ materially from cases of Asiatic cholera. As sufficient individual predisposition is supposed to have been present in both cases, Pettenkofer attributes his own and Emmerich's escape from cholera to the absence of the peculiar atmospheric and local conditions which he believes to be always necessary to the development of the infectious diseases.

The remainder of the paper is devoted to an extended argument in support of this theory. The relation of temperature, atmospheric conditions, rainfall, and the condition of the soil to previous epidemics of cholera are cited, and these are put forward by Pettenkofer as the peculiar climatic and local conditions necessary to cholera.

The paper concludes with suggestions as to the proper measures of prevention. Too much attention is paid to preventing the transport of the cholera bacilli (an impossibility, he says), and too little thought is given to measures tending to counteract the peculiar climatic influences.

It was hardly to be expected that conclusions so radically variant from the generally accepted notion of the causation of infectious diseases should go long unchallenged. In No. 47 of the *Deutsche Medicinische Wochenschrift* S. Guttman reviews the results of the experiments, and finds in them a confirmation of the generally accepted theory rather than of that advanced by Pettenkofer. He believes Emmerich to have suffered from a mild attack

of cholera, and Pettenkofer to have had a choleraic diarrhea. He cited cases in which cholera has unquestionably followed the contamination of drinking-water with cholera dejections. He calls attention to the fact that Koch and his adherents have never insisted that the cholera bacillus is the only etiological factor in the production of an epidemic, but that they believe it to be the one factor without which no case of cholera can occur.

Posner (*Berliner Klinische Wochenschrift*, 1892, No. 48,) further argues that three possibilities in accord with the prevalent theory present themselves in Pettenkofer's experiment: (1) That neither he nor Emmerich afforded the necessary individual predisposition, that they were in a measure immune; (2) that the bacilli were in some way deprived of their fullest virulence, as, for example, by an insufficiently neutralized gastric juice; or (3) that the experimenters really suffered from mild attacks of cholera. He will admit only one thing in any case to have been proven by the experiment, namely, that the ingestion of cholera bacilli is not necessarily always followed by a typical severe case of cholera.

He refers to an interesting observation made this summer in Altona, that cholera developed in those houses in a certain street which were supplied with water from Hamburg, but passed over those houses receiving water from the Altona water supply. He distinctly differs from Pettenkofer as regards the proper measures of prevention in time of a cholera epidemic, believing that our energies should be directed against the one clearly definable factor, the cholera bacillus, without which the disease can not exist, rather than against other less tangible conditions whose agency is speculative, to say the least.

[It should further be remembered in connection with this experiment of Pettenkofer that the virulence of many of the known pathogenic bacteria undergoes attenuation after repeated cultivation on nutrient media, and of none is this more true than of the cholera bacillus. Pettenkofer's culture was obtained from Hamburg, and is said to have been virulent, but it had been cultivated on agar and in bouillon, and the possibility of its having in that way lost a measure of its original virulence suggests itself.—J. S. E.]—*American Journal Medical Sciences.*

CIRCULAR OF INFORMATION CONCERNING THE USE OF BACTERIAL CULTURES BY THE HEALTH DEPARTMENT FOR THE DIAGNOSIS OF DIPHTHERIA.—Recent investigations have shown that a considerable proportion of pseudo-membranous and exudative inflammations of the throat and upper air-passages, commonly considered as diphtheria, and having the anatomical appearances found in diphtheria, are not true diphtheria. These cases may be called false diphtheria.

It has also been shown that a considerable number of cases considered to be false diphtheria are really true diphtheria. While in true diphtheria the mortality is very high and the danger of transmission to others is great, in false diphtheria the mortality is low and the danger of infection slight.

The differential diagnosis between true and false diphtheria can be made by bacteriological examinations within twelve hours, while without their assistance it is difficult or impossible.

The Health Department is now prepared to make use of bacterial cultures for diagnosis in all cases of suspected diphtheria occurring in the city, and desires that in every case either the physicians should themselves make the inoculations, or should authorize an inspector to make them. They should be made in every suspicious case at the earliest possible moment. It is only in this way that the full benefit of a positive diagnosis is obtained, for during convalescence the specific organisms often disappear from the throat. The inoculations are made by gently rubbing a cotton swab against the throat, and then drawing it over the surface of the culture-medium. When the physician desires to himself make the culture (and this is usually the better plan, for it can be done earlier and is more agreeable to the family), he can obtain, free of cost, a culture-tube and swab, and the simple directions necessary for their use, at any one of the druggists whose addresses are given in the circular. After the inoculation the tubes are to be returned at once to the druggist from whom they were obtained. The tubes will be collected by the department every evening. If, on the other hand, the physician desires an inspector to make the inoculation, he is requested to state this when the notification of the case is sent to the department. The diagnosis will be ready in every case by noon of the following day. The attending physician can obtain this immediately by telephoning to the laboratory (1191 Spring), or when this is not done he will be notified by mail. Cases which prove to be false diphtheria will not be visited by the department. Cases, on the other hand, which prove to be true diphtheria will be subjected to the usual rules and regulations covering contagious diseases.—*New Medical Record*.

THE ASSOCIATION MEETING IN MILWAUKEE.—The forty-fourth meeting of the American Medical Association held this week in Milwaukee, a full telegraphic report of the proceedings of which appears in this issue of the *Medical Record*, was one of only average interest. None of the papers read was of extraordinary importance, or could by any stretch of the imagination be described as epoch making, yet there was a fair sprinkling of good ones—enough, at least, to make the meeting a fairly successful one. A feature of the section meetings, and one that is of promise for the future, was the higher tone of the discussions following the presentation of set papers in several instances, while the papers themselves were mediocre. The discussions which they elicited were instructive, and brought up many points of genuine value.

The anticipated battle over the Code question was avoided by the action of the committee in asking for another year in which to complete the draft of a new Code. It was significant, however, that the changes which the committee advised in its report would be radical enough to make the new

instrument practically as liberal as the one adopted some years ago by the Medical Society of the State of New York, and which was the cause of the present "unpleasantness." It is safe to say, however, that the new Code will not be adopted next year without a pretty sharp struggle, for the conservative element in the Association may succeed in postponing the inevitable for a few years yet. The nomination of Dr. Hibberd to the presidency was in the nature of a compromise, yet the choice was a happy one, and the Association is to be congratulated upon having so accomplished a physician to preside over its deliberations for the coming year.—*Medical Record*.

INOCULATION OF MEASLES.—Dr. Hugh Thompson, of Glasgow, describes nine cases in which he had inoculated children with fresh serum taken from blisters on patients suffering from measles. He believes that four were rendered immune, and that in two the experiment failed. At the point of insertion of the serum slight measly looking patches appeared in from one to two days, and lasted for two or three days, accompanied with slight catarrhal symptoms. The serum is taken from small blisters no larger than a measly patch, and used immediately, and inserted by superficial scarifications.

AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.—The third annual meeting of the American Electro-Therapeutic Association will be held in Chicago, September 12, 13, and 14, 1893, at Apollo Hall, Central Music Hall Block. Members of the medical profession interested in electro-therapeutics are cordially invited to attend.

MARGARET A. CLEAVES, M. D.,
Secretary.

DURING the course of a laparotomy, when the surgeon wishes to know which end of a divided coil of intestine is on the stomach side, it is only necessary to touch the peritoneal coat of the bowel with a crystal of sodium carbonate, the effect of which is to cause contraction in the direction of the stomach.—*The Medical Press*.

THE NEW YORK ELECTRO-THERAPEUTICAL SOCIETY was reorganized Friday evening, June 9th, and elected the following officers: President, Dr. W. J. Morton; Vice-President, Dr. Augustine H. Goelet; Secretary and Treasurer, Dr. O. S. Phelps. The next meeting will be held in October.

PROFESSOR JACOB MOLESCHOTT, the celebrated physiologist of Rome, died on May 27th, aged seventy-one. He was for a time professor in the University of Turin and a senator of the kingdom.

PRESIDENT CARNOT has had an attack of appendicitis complicated with cardiac troubles.

Special Notices.

ARISTOL IN HEMORRHOIDS.—To establish a radical cure, all causes to be ascribed to a faulty diet, strong drink, or want of exercise must first be removed. Then every morning and night, and in severe cases every three or four hours, about one ounce of cold water is injected into the rectum and allowed to remain as long as possible. Morning and night the following suppository is applied.

R Extracti opii, grs. iij;
 Extracti belladonna, gr. j;
 Quinia muriat., gr. xxvj;
 Aristol, oz. j;
 Olei theobrom, } aa q. s. et fiat suppository No. vi.
 Cerae albae, }

Sig: One morning and night.

Immediately after each movement of the bowels, the following salve spread over the point of the index finger, is pushed up into the rectum for about one and a half inches, and some upward pressure is exerted by the external sphincter:

R Unguent zinci benzoat., oz. j;
 Balsam Peruvian, dr. j;
 Aristol, grs. xxx.

M. ft. ungt. Sig: Externally.

While internally, from one to two heaped teaspoonfuls, in plenty of water, are taken two or three times daily of the following powder:

R Sulphur, flor., } aa oz. ij.
 Potass. bitartrat., }

M. ft. pulvis., S.

—Engle, *Medical Summary*.

TERRALINE IN PULMONARY DISEASES, by H. E. Woodbury, M. D. Terraline or refined petroleum is one of the comparatively new coal-oil products, and merits the consideration of the medical profession as one of our best remedies for all pulmonary diseases. I have recommended it to other parties, and used it in my own family with satisfactory results, as it is not apt to derange the stomach and has not the disagreeable taste of cod-liver oil. The dose is small, and this renders the medicine inexpensive. As this remedy becomes known I feel sure it will be more highly appreciated and fill a desideratum that has long existed.

Those who give it a trial will find it a most desirable substitute for the less agreeable preparation of cod-liver oil.

WASHINGTON, December 1, 1892.

CHRONIC NASAL CATARRH:

R Creosote (Beech Bark), 2½ minims;
 Glycerine Conc., ½ drachm;
 Kennedy's Ext. Pinus Can. (dark), ½ drachm.

M. Cleanse both the nostrils out thoroughly with warm rainwater and pure sweet milk, equal parts, with a small quantity of table salt dissolved therein. After which apply to the inside of the nostril the above mixture, requesting the patient to snuffle sufficiently strong to give him a creosotic taste to the mouth.

DELIRIUM TREMENS.

R Tinct. capsici, ½ oz.;
 Peacock's bromides, 1 oz.;
 Celerina, 2½ oz.

M. Sig: Teaspoonful, in water, as required for wakefulness and excitement.

THE AMERICAN PRACTITIONER AND NEWS

"*NEC TENUI PENNĀ.*"

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No. 13.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

A REPORT ON CHOLERA INFANTUM.*

BY LYMAN BEECHER TODD, M. D.

In asking your consideration of the subject of cholera infantum, that great bane of infantile existence, I purpose briefly to present a †summary of the prominent current literature and practice of the profession concerning it. Time and the proprieties of this occasion forbid minute description of the anatomical structures involved, and the physiological functions thereof. Nor does the province of this paper justify the recital, however pleasant the task would be, of the learned and elaborate theories of the text-books; but rather would I mention certain characteristic pathological changes and conditions, and gather experiences that the past year has furnished, as ripened fruit and garnered grain, the results of the scientific thinkers, the every-day thoughtful workers, the intelligent and studious physicians, whose bedside observations are very valuable to us.

The importance of this subject is appreciated when we remember that cholera infantum takes fifth rank in the mortality of generally prevailing diseases, as shown by carefully prepared statistics of seven State Boards of Health, where sanitary principles are most regarded, and in this order: consumption, typhoid fever, diphtheria, dysentery, cholera infantum.

Let it be borne in mind that the starting point of this much dreaded and fatal disease is usually an acute dyspeptic diarrhea, a catarrhal

*Made to the Kentucky State Medical Society at the Meeting at Frankfort, Kentucky.

†Valuable assistance in the preparation of this paper has been received from the Medical World, June, 1892, whose watchword is, The knowledge that a man can use is the only real knowledge.

inflammation of mucous membrane of the stomach, extending into the intestines. Primarily the trouble is functional, and secondarily it is the result of a true inflammatory enteritis. It is a disease of the hot months, and usually occurs in children under two years of age. The name, cholera infantum, designates the violence of the symptoms, which closely resemble those of Asiatic cholera, and when the latter terrible malady is prevalent the differential diagnosis is difficult if not impossible.

The common causes of cholera infantum are impure air, the result of animal and vegetable decomposition, overcrowding, personal and domiciliary uncleanness, and, it has been asserted, from putrefactive changes going on in the intestines from poisons formed within the body, and perhaps in the great majority of cases by improper food. Hand-fed infants who are deprived of wholesome breast-milk suffer most, owing to the decomposition and contamination of milk. Among these the mortality is very great, eighty or ninety per cent. The symptoms presented are the sudden and abrupt commencement of the attack. The parents say that "the child only a few hours before was apparently well." Evacuations are very frequent, watery and serous, that soak into the napkin like urine, and are often colorless, with an odor which is musty and offensive. It is said that these alvine discharges, to which rapid prostration is so largely due, consist in part of intestinal secretions and serum which has transuded from capillaries of intestines. The pulse is rapid and feeble. The irritability of the stomach is constant and persistent, throwing up every thing that is swallowed, which greatly increases the prostration and danger. Thirst is intense; indeed, insatiable. Appetite lost; temperature 105° to 107° ; restlessness. The urine is scanty, uremia causing cerebral disorder. The loss of strength and emaciation is rapid, far more so than in any other diarrheal malady except Asiatic cholera. Eyes are sunken, the eyelids and lips generally open, and most dreadful of all is collapse.

What a picture is this of innocent helplessness; of danger, if not also of hopelessness?

But the question most pertinent and most important is, what shall we do? And if eternal vigilance is the price of liberty, and if it is rewarded here it will be the price of a precious life.

The diagnosis of cholera infantum depends upon the presence of uncontrollable vomiting and diarrhea, intense thirst, rapid shrinking of the body, copious serous discharges, and collapse; suddenness, and often violence of attack.

The prognosis in well-marked cases is extremely grave. In excessively hot weather, when collapse is established, death almost invariably ensues.

The morbid anatomy is not considered very characteristic. There is evidence of catarrhal enteritis, with denudation of epithelium and enlargement of solitary glands. Follicular ulceration is frequent, as also is nephritis. There is a profound affection of the nervous system. It has been said, and I believe said truly and wisely, that to establish the integrity and control of the nervous supply governing the digestive tract is to cure the disease. A learned practitioner has declared that cholera infantum is as undoubtedly of bacterial origin as is Asiatic cholera.

Cholera infantum is considered due to a poison of the toxalbumin type, and has been pointed out by Professor Vaughan, and very properly called by him tyrotoxinon. This ptomaine is found in the milk under certain conditions and circumstances, which if properly studied will give a satisfactory explanation both of the time of attack and the mode of invasion. It may also suggest the proper therapeutical treatment.

It is indeed comforting to know that an eminent physician of extensive practice in a city having the fourth largest population in the United States has said, taking all the cases of summer complaint that he has seen during the past ten years, not one case in twenty has been true cholera infantum.

For encouragement concerning cholera infantum, let us "not despise the day of small things." You have seen the pebble in the brook turn aside the current of the stream that moves the mill miles away. Upon a sultry afternoon in August, 1864, I visited a little child, exhausted apparently to extremity by continuous vomiting and purging, with a restlessness almost beyond endurance, which could be quieted only by the motion of the little carriage in which I found her lying. The father's first remark, "Doctor, she throws up every thing that she swallows, and purges all the time," gave the key to the pitiable and perilous situation. Best French brandy was quickly brought, of which twenty drops in crushed ice were given with regularity every half hour. The stomach and bowels were kept well covered with warm spice poultices. After four hours, during which the little patient had slept considerably, which for ten hours previously she had not done, I gave one grain of calomel dry on tongue. This was repeated hourly until five grains had

been taken. She was thereafter closely watched, carefully nursed, and judiciously nourished. She is to-day the happy mother of a happy family now residing on Broadway in our city. During the night in midsummer, a few years since, I was hurried to see a little child that was "very ill." She was brought to me, carried upon a pillow in the tireless arms of her mother. Under the subdued light of the chandelier she indeed seemed lifeless. "I have been walking and rocking her for hours," said her mother, "and can not quiet her; her stomach and bowels are, I am afraid, beyond control." A few drops of iced champagne were regularly given every twenty minutes, and warm spice poultices were kept over the entire front of the body. I remained all night. At daylight all was quiet on the canal alimentary. One grain of calomel was given every hour for four hours. No other medicine, but nourishment judiciously was given. I can never forget her appearance as she lay upon that pillow that night. I frequently meet her on the street as she returns from school—one of the prettiest girls in Lexington.

Speaking negatively of cholera infantum, it is not confined alone to overcrowded localities in cities, but has prevailed with alarming fatality in country towns and suburban homes. It is not so much relieved by medical treatment, treatment by drugs, as by preventive and hygienic measures. It is not generally benefited by opium and vegetable astringents *per orem*. They lock up the poison within the system; they obstruct the secretions, and hasten the fatal end.

It is not due to a certain or a single cause, nor always to the same combination of causes. It is not identical with summer complaint. Certain intelligent and reputable practitioners rely, in the earliest stages of cholera infantum, upon very large doses of calomel to arrest or abort the poison and violence of this disease, giving at one time twenty grains and repeating it. This I never did. But as soon as the stomach can tolerate it I have administered small doses of calomel, one grain given hourly until five grains have been taken, with satisfactory benefit. In that manner given, or even five grains given at one time and repeated, I regard calomel the sheet anchor in cholera infantum, together with supporting treatment and appliances for the comfort of the little patient, to which I shall hereafter refer.

My friend, Dr. Larrabee, whom you recognize as excellent authority, called the attention of the profession some years since to the beneficial effects of hypodermic medication in the treatment of cholera infantum, giving injections of one fiftieth of a grain of morphine and

one one-hundred-and-fiftieth of a grain of atropine to control the nervous disorder. This is to be followed by small doses of calomel, lime-water containing a little carbolic acid, allowing toast-water only for nourishment for thirty-six hours. I remember how enthusiastically he asserted that by this treatment death from cholera infantum would be the exception. He believes that the most important element in the treatment is prophylaxis to secure immunity from the disease. He says that the formation of poisonous alkalies in the milk used by infants who are deprived of mother's milk causes the trouble, which can be prevented by sterilizing the milk at 212° F. Then such poisons can not be developed. If there be restlessness, enemata of boiled starch to the consistency of syrup, containing a few grains of chloral and bromide of potassium, is indicated. Pepsin acts as a sedative to the stomach, and aids digestion, and vomiting is often controlled by pepsin and bismuth and spice poultice. Arsenic and arsenite of copper are recommended on high authority, and I believe during the past year they have been largely used, though Dr. Woodbury says that "the occasion rarely arises, in my opinion, where it is prudent or safe to use them." Close study and observation should be given to all peripheral sources of irritation, dentition, phymosis, etc.

I know that you regard, as I do, hygienic measures essential in the treatment of cholera infantum. Intestinal antiseptics is here a very important factor, which practically means the keeping of the stomach and the bowels pure and free from all abnormal, fermentive, or putrefactive changes, for which salol is highly recommended in small doses, or salicylic acid with the addition of sodium bicarbonate, and bismuth, if desired.

Food, good and nutritious food, properly prepared and given at regular intervals, is of highest importance. I have derived great benefit in severe cases of cholera infantum from the use of Fairchild, Bro. & Foster's (New York) peptogenic milk powder, which yields the best physiological substitute for mother's milk, especially where great exhaustion and intolerance for food exists. It seems particularly acceptable to the stomach, and certainly is easy of proper assimilation, and thereby subserves the needs both of general nutrition and of the nervous system.

For an excellent tonic for suppurative treatment I have used with happy and most satisfactory results a few drops, regularly and frequently, of Fellows' syrup of hypophosphites. It is certainly valuable

and reliable on account of its ready assimilation into the blood, its action in restoring tone to the nervous system, its assistance in the assimilation of food, and the aid it affords in the manufacture of the blood cells. Extremes of temperature should be avoided. Perfect cleanliness of person, tepid or sponge bath as heat and other conditions of the skin require, cleanliness of clothing and of the bedding, abundance of pure air inside and outside of apartments, plenty of pure water, clothing suitable. No portion of the body should be clothed so warmly that perspiration should be easily increased, since a rapid loss of heat is caused by evaporation. To prevent rapid loss of heat, underclothing of wool should always be worn. Wool is the best material that can be used to prevent rapid evaporation, and at the same time to allow the air to ventilate the skin. All parts of the body should be kept equally warm. Disinfectants should be used.

Chilliness and coldness of the surface of the body in cholera infantum is greatly to be dreaded, and all possible means should be employed to prevent and to overcome it. A most admirable and satisfactory contrivance for securing and for preserving heat and comfort I saw used at an institution for foundling infants which I recently visited. It is known as the water-bed, and is worthy of your attention as an excellent appliance for heating the body in the cold stage or collapse. It is an India rubber water-bed of any size desired for the sick. It is placed upon the bed alongside the patient, and is partially filled with water at a temperature of 140° or 150° F., and covered with blankets, upon which the patient is laid. The weight of the body carries it down and forces the water up at the sides, so that the person is partially surrounded by the heated water. The mass of the water and the protection of the blankets prevent the loss of heat, so that the mattress keeps hot for many hours. Patients even in collapse or with subnormal temperature and profuse sweating have been relieved by the hot water-bed. All that would be necessary to maintain continuously equal and desired heat, temperature rather, would be to have the water-bed supplied with two nozzles and a rubber tubing fastened to each nozzle, one connecting with the spigot, and the other outlet with the neighboring bath tub or with a stationary washstand. This could easily be obtained, if not from a druggist, by telegram from cities in a few hours. I earnestly recommend its use. It has also been esteemed especially useful in the treatment of adults with fever.

Do I read rightly your expressions, my friends, that I weary you

thus with details? Let me but remind you that to be victorious the battle with this enemy, cholera infantum, must be fought in detail. You remember that the great Napoleon attributed his most brilliant achievements to his attention to the details of the campaign. See to them yourselves. Never be in haste to leave a patient in this condition. Stand guard yourselves on the deck, because the little bark is frail, and the storm rages high. Your little suffering patient is in great peril, and will appeal to you eloquently, though mute and voiceless: Stay by me until morning. Did I not thus insist upon your watchful and careful attention to details in the treatment of this disease, I would fail of justice to you, my friends, in the discharge of the trust reposed in me and the duty assigned me by this Society on this occasion.

In presenting this subject of cholera infantum, so important to us all and to our respective communities, a disease of the hot season, at this time, I take Old Time by his forelock; and when that heated term shall come to us, when by reason of the burden of the heat the lad in the field cried out, "My head! my head!" whom the men carried to the house to die in the arms of his Shunamite mother—then when you shall be called to treat cholera infantum, this disease which has taxed to the utmost the knowledge, the skill and ingenuity of even those who are best prepared, if at that time should any thing said or even suggested in this paper benefit you I shall feel more than compensated for its preparation.

LEXINGTON, KY.

REPORT ON THE RECENT ADVANCES IN OPHTHALMOLOGY.*

BY JOHN Y. OLDHAM, M. D.

This branch of medicine, as you are all aware, was about the first specialty to attract the physician's attention and demonstrate to him what might be accomplished by the separation of medicine into special departments. Although there have been rapid advances in the various other departments of medicine, this particular one has always kept abreast in the development of that science which has for its goal the health and welfare of the human race.

The advance in ophthalmology should be particularly interesting to the physicians in each branch, inasmuch as it pertains to an organ

* Read at the Meeting of the Kentucky State Medical Society, May, 1893.

upon the healthy condition of which depends our ability to keep abreast of the times.

The eyesight is an all-important essential to each of us, therefore it necessarily follows that we should have at least a limited knowledge in regard to the preservation of it.

It is true that the ophthalmologist knows a great deal about this little organ and the various pathological conditions to which it is liable, yet there is a great deal to be learned. In some cases of blindness we prove a blessing to humanity, and in many others we are of little use. Headaches, neuralgias, and many other reflex disturbances are frequently relieved or alleviated by the correction of some error of refraction, yet we meet other disturbances over which we have little control. It is no unfrequent thing to meet an apparent eye trouble which proves on close examination to be but the reflection of some other organ diseased. In regard to headache due to eye troubles, Dr. Casey A. Wood (in the Chicago Medical Record) divides it into seven classes according to the frequency of the disturbance: "(1) supraorbital, (2) deep orbital, (3) intracranial, (4) temporal, (5) supranasal, (6) the vertical, (7) occipital. As exciting causes, aside from acute and chronic diseases, he attributes to the tasks of convergents and accommodations, also, that in numerous instances the pain does not occur until the following day."

In the treatment of that unfortunate disease, granular ophthalmia, we have as yet no one remedy, either mechanical or medicinal, that is universally accepted by the profession as *the* remedy for this disease; the opinions and treatment are various and variable. We do agree as to the constitutional requirements, and if we accept the majority of the text-books on this subject, nitrate of silver in from a one-per-cent solution to the mitigated stick sulph. copper, a knife, and a pair of scissors would constitute the local treatment. In many cases the above remedies answer, but unfortunately we meet with cases in which they prove ineffectual. In the treatment of this affection Darier, chief of Abadie's clinic, gives, as followed in that service, "first a general anesthetic; he then completely everts the lids by special forceps, the granulations are thoroughly scarified with a grattage knife, to be followed by a scraper and stiff brush until all the morbid tissue is destroyed and brushed away; this to be followed by thorough cleansing with cotton wool moistened in 1-500 solution of corrosive sublimate and frequent bathing with 1-2,000 solution of corrosive sublimate and ice compress."

Dr. Edward Jackson (Medical and Surgical Reporter, August, 1892,)

as a mechanical treatment of trachoma prefers Knapp's corrugated roller forceps, as its use is not followed by contraction, and in the majority of cases it does not require a subsequent operation. "He claims that while incision of the granules and sago-like masses and excision of the retrotarsal fold abridges the course of the disease, it leaves a contracted conjunctival sac. Also grattage of the entire surface, followed by the stiff brush, will cut short the disease, but leaves too much contraction behind." Chevallereau, as a treatment of the same affections "uses cocaine, everts and holds the lids apart with his left hand, then by attaching a compress soaked in 1-500 sublimate solution to right index finger he makes firm and vigorous friction over the entire conjunctiva of the lids and canthi. The results he reports as good. Of the different mechanical treatments I agree with Dr. Jackson in the preference of Knapp's improved roller forceps."

A new operation for congenital ptosis, by Dr. Gillet de Grandmont, is described as follows: "Seize the upper lid with Snellen's forceps, cut through the skin parallel to the free border of the lid, the incision being three or four millimeters from the border and about two centimeters in length. (2) Raise this cutaneous flap, detach and excise the corresponding portion of the orbicular muscle so as to expose the entire tarsus from the ciliary border to and including the tendon levator palpebræ. (3) Cut through the entire thickness of the tarsus to the extent of two centimeters parallel to the free border of the lid from two to four millimeters. (4) Describe a curvilinear incision, the cavity downward and extending from one end of the first incision to the tarsus of the other; this incision should extend through all the tissues of the lid including the conjunctiva. (5) The upper or orbito-palpebral flap should then be stitched to the lower or tarsal flap by three sutures without touching the skin."

Dr. Eugene Smith (Detroit) gives us the following as a new method of operating in the annoying and often distressing affections, trichiasis, districhiasis, and entropion: "After placing a Snellen clamp on the lid he makes an incision with a Beer's knife along the free border of the lid between the faulty and normal cilia. The incision to be carried well up to the hair follicles, which are usually plainly seen after the hemorrhage has been arrested. In case the wound does not gap, which it usually does, then lift the anterior lip of the wound with a pair of forceps; this will bring into view the hair follicles, which must now be delicately touched with a very fine pointed galvano-cautery electrode,

exercising great care not to destroy or obliterate the canals of the tarsal glands and thereby cause tumors and contractions of the cartilage. After destroying the follicles of the offending ciliæ wash the parts in a 1-5,000 sublimate solution, place on the closed lid a pledget of cotton dipped in this same solution and fasten with adhesive plaster. This dressing should be left on twenty-four hours, by which time the wound is usually united. In mild entropion with slight incurvation Dr. Smith makes a groove in the cartilage."

Dr. Guaita having performed an operation three hundred and fourteen times to induce quick healing in dacryocystitis with good results, describes the method of procedure as follows: First, curette the lachrymal sac and introduce a decalcified bone canula in the lachrymal canal, which has been previously widened by an incision. The operation to be done under strict antiseptic precautions. He cautions the operator on the introduction of the canula to exercise great care lest it fold upon itself and thereby prevent introduction into the canal.

We have, in the Medical News of January, a case of homatropia susceptibility reported by Dr. George M. Gould. He used an eight-grain solution and did not exceed two drops. This resulted in great swelling of the lids. The cheeks for two inches below were puffed and discolored. In this regard I wish to report a case of poisoning from this drug. On February 10th Miss F. H. F. called at my office to consult me about her eyes. After asking her a few questions I decided she had an error of refraction, and at once began to instill in her eyes a solution prepared the day previous, containing four grains of homatropinia hydrobromatis to two drams of distilled water. This I dropped in her eyes every five minutes for half an hour. After waiting one hour from the last drop instilled in her eyes, I called her in to test them. I noticed, as she came toward me, that her gait was unsteady; but being a child fourteen years old, and an exceedingly nervous one, I paid no attention to it; but when she failed to enunciate her letters with distinctness, I asked her if she felt badly; she replied that she felt slightly nauseated. Within ten minutes she lost complete control of her lower limbs, this being quickly followed by drowsiness. Pulse rapid and fluttering. I gave her a stimulant and one eighth of a grain of morphia. I then called in Dr. Young to assist me. He gave her the second dose of morphia one hour after the first. It was four hours before she was perfectly conscious, and at least six hours before she had good use of her limbs. On the following morning I found she had hypermetropia, $\frac{20}{120}$. The pupils remained

dilated for three days. I was sure of my drug because I had used it the day previous, the same day, and also the following day without any other unfavorable symptoms. I can account for this unusual case only on the grounds of a peculiar idiosyncrasy.

The improvements in cataract operations in the last few years, and especially in regard to the after-treatment, has been very great. We have now no more dark rooms, milk diet, and almost solitary confinement. Instruments have been improved and many new ones devised. At present nearly all our instruments are constructed so that they can be thoroughly cleansed and treated antiseptically.

Gruening has constructed a set of ophthalmic instruments, exclusive of knives and scissors, the handles of which are made of platinum and iridium, which may be sterilized by heat in the fraction of a minute. A new instrument devised by Black, for removing foreign bodies from the cornea, consists of a round needle-like shaft, the end of which is flattened and the extreme tip slightly hooked, making it spoon-shaped, and useful either as an elevator or tractor.

Dr. S. M. Payne has a knife for the removal of pterygium, which has a flat curve, double-edged point for about one third its length, the remainder of the blade being dull. He has also devised an eye speculum which is an improvement on the wire speculum for lightness and strength. I received from Mr. E. B. Meyrowtz a cut of his improved registering proimeter; the improvements make it simple and more practical.

Pyle has devised a self-retaining lid elevator, the object of which is to do away with a speculum and an assistant in cataract operations. He also presents to us a fixation forceps, the jaws of which form the segment of a circle corresponding with that described behind the limbus of the cornea. His claims for this are that a larger amount of the conjunctiva can be seized, and at the same time the eye is so embraced as to effectually prevent the rotation of the eye on its horizontal and vertical axis. We have a new ophthalmoscope constructed by Jackson, an optometric and ptakometric ophthalmoscope devised by Parent, an electrode by Knapp, for cauterization of corneal ulcers, as well as an improvement in his roller trachoma forceps, which consists in the ready removal of the steel roller, thereby making it entirely antiseptic. In fact I might spend some time in enumerating the recent improvements and inventions, but I feel that I have already consumed too much of the valuable time of this Society, and that I must thank you all for so patiently bearing with me.

REPORT ON GENITO-URINARY SURGERY.*

BY W. R. BLUE, M. D.

Amid the general advancement that has characterized all branches of practical medicine during the past year none can show greater progress than that of genito-urinary surgery. New remedies, new instruments, and modified old ones lauded by their manufacturers and advocates have appeared from time to time; a few have stood the test, but the majority weighed in the balance of practical experience, and found wanting, have gone the way of so many others that gave us fair promise in the beginning.

It is unnecessary, though time permitted, that I go into the etiology and pathology of all the diseases that come under our care. I shall endeavor in as full and concise a manner as I am able to describe the management of the most common diseases that we are called upon to treat, the results obtained in these cases by eminent men at home and abroad, together with such points as have from day to day come under my own observation.

Gonorrhea I mention first, since, of all the diseases that we are called upon to treat, it is the most frequent, and along with its numerous complications the hardest to subdue. How often have we seen cases of this universal malady going along beautifully, when suddenly there comes a change, and that, too, without any apparent cause, and despite all precautions. Our patient reports one day all smiles; discharge all gone; no pain; apparently well. We congratulate him and his doctor only to be summoned the following day to his bedside, where we find him suffering intense agony from an epididymitis, or, perhaps, a cystitis or prostatitis, and it is oftentimes hard to convince our patient that our treatment is not responsible for it. Its duration we can not foretell; its termination no one knows. We may cure one case in a few days or weeks, another may linger for months or years, a constant reproach and a reprobate to all treatment.

During the year just passed I have treated 31 acute cases of gonorrhea with an average duration of 38 days. I rely on self-treatment altogether, and with this result, that in none of these cases were there any complications. I will outline my treatment:

First, I order a diuretic, preferably potassium acetate in teaspoonful

* Read at the May Meeting of the Kentucky State Medical Society.

doses every four hours, taken in half glass of water, and continued from five to seven days, or until the subsidence of acute symptoms. A proper syringe is no small item. I order a Goodyear No. 25, soft tip, capacity four drams with this I have patient use the following washes : First, hydrogen peroxide 10 vols. (I prefer the Oakland Company's as being less irritating), a syringe-ful after urinating, at least four times daily. This removes effectually any discharge left, thus placing the diseased surface in fit condition to get the best results from the injection which follows. I append the following, a favorite wash of mine :

| | | | |
|---|--|------------------|----|
| R | Resorcin, | 3j ; | |
| | Zinc. sulph., | gr. vj to xvij ; | |
| | Glycerine, | 3vj ; | |
| | Boric acid, sat. sol. q. s. ad., | 3vi. | M. |

In case there is much pain I add one dram of aqueous extract of opium. Under this treatment the discharge as a rule ceases in from four to fifteen days. Many combinations of the zinc and lead salts, unnecessary to mention, will suggest themselves according to the case.

Dr. Glenn, of Nashville, Tenn., in a recent article (Journal of Cutaneous and Genito-Urinary Diseases, April, 1893,) reports excellent results from the use of zinc iodide, 1 grain, and zinc chloride, ½ grain, to water 1 ounce. Of 24 cases treated, in all of which the presence of the specific germ was demonstrated, the average duration under this treatment was only sixteen days and seven hours. Deeming this method worthy of trial I have placed several cases on it, and hope at some future time to report results. Dermatol is still *sub judice* ; as for myself I have been unable to obtain the flattering results reported by its advocates.

Alumnnol is the latest candidate for favor in the treatment of gonorrhea. According to Chotzen (Notes on New Pharmaceutical Products, February, 1893,) a one- to two-per-cent solution injected three to four times daily causes the complete disappearance of the gonococci in from three to six days. I have used with but little effect as much as a four-per-cent solution.

Jadasshon, of Breslau (London Lancet, December 10, 1892), speaks highly of ichthyol. In anterior urethritis injections gradually increasing in strength from one- to five-per-cent solution, and in the posterior variety from one to ten, may be used. A one-per-cent solution exercised a decided anti-gonorrheal action in most cases, the specific germ disap-

pearing more rapidly than with any other method of local treatment. In a certain number of cases it, like other remedies, failed; many cases unsuccessfully treated with nitrate of silver were cured by ichthyol, and *vice versa*.

I have abandoned entirely retro-injections and irrigations of the bichloride of mercury in this disease. They neither shorten the duration of the disease, nor have I seen marked benefit result from their use.

In the chronic form of the disease under discussion, the urethroscope, in its present perfected form, supplies a long-felt want and is an indispensable aid in its treatment, enabling us as it does to examine the entire urethra, thus locating the exact seat of the trouble and affording a ready means for the direct application of the remedies, nor is it alone applicable in the treatment of urethral troubles. As an aid in the removal of growths and foreign bodies in the urethra it is indispensable.

In urethritis granulosa, so-called, I apply through the urethroscope sulphate of copper in stick, the surface having previously been mopped off with absorbent cotton. The instrument is passed beyond the diseased surface and withdrawn until it comes into view, the copper on a slender pencil is then applied.

In that condition known as urethritis sclerotica nitrate of silver is the remedy *par excellence*. A solution of 5 grains to 1 ounce of water applied on a swab usually suffices when the disease is not of long standing; much stronger solutions are necessary in the latter instance. Two to three applications a week are sufficient, and few are the cases that resist the remedy.

Packings of dermatol, iodoform, and boric acid have not given me such results as the silver and copper applied as stated. Sulphate of copper is likewise our most effectual agent in the treatment of erosions, ulcers, and chancroids of the urethra.

We come now to the complications of gonorrhea. A mere list of all of them would consume much time, nor is it necessary that we consider the more remote ones. In point of frequency posterior urethritis has first claim to our consideration. Diuretics and, if pain and tenesmus be present, suppositories of opium and belladonna, along with bi-weekly injections of silver nitrate in strength varying from 5 to 60 grains to the ounce of water with the Keyes-Ultzman syringe, is good treatment. The efficiency of this treatment has increased its popularity in the past year, and it is doubtful if a better can be found.

Epididymitis next claims our attention. In this trouble the dry poultice of Langlebert, described to you by Dr. E. R. Palmer at our last meeting, is our most efficient agent at the onset. When pain and swelling are present the time-honored flaxseed tobacco poultice secured by an improvised suspensory along with complete rest in the recumbent posture, is still the accepted mode. When pain and swelling subside it is good treatment to apply the dry poultice as mentioned, held in place by snug-fitting suspensory.

A passing notice of recent methods of treatment is of interest.

Halstead's method (*Genito-Urinary Diseases*, Vol. 1, Morrow,) consists in lightly touching the skin overlying the affected organ with a white-hot caustery point. He next applies an iodoform ointment secured by a suspensory. He claims that the application requires but a few seconds, and, if made skillfully, instant relief from pain in most cases, with the patient able to be up and about in comparative comfort. This is certainly heroic treatment, and I doubt if we can persuade patients in private practice to submit to it.

Prostatitis following gonorrhea is best treated by rest in bed, along with hot rectal enemas and sitz baths three to four times daily, leeches to the perineum and an anodyne suppository of opium and belladonna for pain and tenesmus. The application of cold to the prostate through the rectum has found favor with some German surgeons. (*Genito-Urinary Diseases*, Vol. 1, Morrow.)

In cystitis there is little new to mention as regards treatment. Daily washings with a warm saturated solution of boric acid, and the same drug given internally in ten-grain doses three or four times daily produces very gratifying results. Flushing the bladder with nitrate of silver solution 1 to 5,000 or 1 to 10,000, is still advocated by many. I prefer the boric-acid treatment as giving me better results.

As regards the treatment of stricture, it is now about narrowed down to gradual dilatation and cutting, except in those cases where immediate interference is necessary; when rapid divulsion is brought into play, followed later on by urethrotomy. Should a stricture of large caliber in the pendulous urethra be diagnosed, an urethroscopic examination should follow. If it prove to be cicatricial, be it ever so large, I hold that the cutting operation is indicated. If not cicatricial, gradual dilatation or meatotomy will generally effect a cure. There is no doubt in my mind but hundreds of non-cicatricial strictures are cut annually, where a simple enlargement of the meatus was the only interference necessary.

In close stricture of the pendulous and membranous portions of the urethra, the Otis and Maisonneuve instruments, followed by bi-weekly soundings and daily flushings of the urethra with warmboric-acid solutions, do the work admirably. As a preparatory treatment, and to lessen danger from septic trouble, ten-grain doses of boric acid are given at intervals on the day preceding the operation.

The danger from hemorrhage following internal urethrotomy in the deep urethra, so much dreaded and talked of by our brethren in the East, has thus far never occurred with me. I find that the closer the stricture the less the hemorrhage. I may say, that I have performed the deep operation eleven times successfully, and in no case was the hemorrhage so great as in strictures operated on in the pendulous portion.

I consider that external urethrotomy is indicated only in those cases of impermeable stricture where, with the patient anesthetized, we are even then unable to enter the bladder with filiform bougies. A favorite method with Mr. Harrison in close stricture consists in the use of his elastic whip bougies, which gradually taper from a point up to 12 to 14 English. This he follows with steel sounds up to 16 or 18. I, however, saw him use the Maisonneuve frequently.

Rapid divulsion with the Thompson instrument is a thing of the past, since the operation often did more harm than good, lacerating healthy tissue which in time becomes cicatricial, thus leaving the urethra in a far worse condition than before.

Along with the urethroscope, which I mentioned earlier in the paper, the cystoscope, as an aid in the diagnosis of obscure vesical and kidney troubles, demands our earnest attention. Cystoscopy is gradually gaining ground and converting the skeptical. Of course there are and always will be some men in the profession who, unacquainted with its merits, will condemn it, but those who work with it constantly, learn to appreciate its value. The cystoscope, like the O'Dwyer instrument for intubation, and like it opposed in many quarters, has come to stay. From personal observation and experience, I am convinced that we have in it a most valuable addition to genito-urinary surgery. I am supported in this statement by the opinions of many men who have labored to make this work a success; among them Meyer, of New York, Fenwick, of London, and Grünfeld, of Vienna. I confess that I have made false diagnoses with the instrument, but we must remember that cystoscopy is yet in its infancy; but I am at the same time consoled and encouraged in the reflection that like mistakes occur in the older branches of surgical diagnosis.

Before passing on to the consideration of buboes we will give passing notice to the local lesions that daily come under observation. Numerous remedies have from time to time been recommended in the treatment of chancroid, chancres, and abrasions, but up to date none have the value of our sweet-scented friend, iodoform. Aristol, dermatol, per-aseptol, and europfen I have used; the latter only gives any thing like the results obtained with iodoform. Cauterization is now only resorted to in sores that are serpiginous, or threatening to become so.

In a recent article on the "treatment of buboes, syphilitic, chancroidal, tubercular, and traumatic, and the attempt to cure by first intention," Dr. Watson, in twenty cases, had most excellent results by excising and removing all diseased and necrotic or semi-necrotic tissue. He then cures the under surface of skin flaps, swabs the wound thoroughly with dry sterilized gauze sponges, or sponges wetted with corrosive sublimate solution 1 to 4,000; lastly a sterilized gauze dressing is applied. He cautions against the wounding of important blood-vessels and advises the tying of all lymph ducts that have suffered division. He had no deleterious results to follow in any case, with this advantage, that he was able to discharge a patient in two weeks instead of from three weeks to two months, as when the wound is allowed to heal by granulation. In ten cases union took place by first intention; average duration sixteen days. In those healing by granulation the average duration was thirty-four days. (*Genito-Urinary Diseases*, February.)

While not doubting the excellence of this method and the results obtained thereby, the difficulty in private practice is to get our patients to lay up for two weeks or more. A less difficult and simpler method is that proposed by Otis, the younger, in the May number of the *Journal of Cutaneous and Genito-Urinary Diseases*. The usual precautions are observed in rendering the field of operation aseptic. A small incision is then made and the contents thoroughly evacuated by gentle pressure, the cavity irrigated with a 1 to 1,000 bichloride solution, and by means of an ordinary glass clap-syringe at once filled to moderate distension with warm ten-per-cent iodoform ointment. Immediately on withdrawal of syringe a compress wet in cold bichloride solution is applied which congeals the ointment, thus sealing the cavity and preventing the escape of injection. A large dry compress of bichloride gauze is next applied, covered by a protective dressing of cotton, and this held in place by means of a firm spica. After four days, if all is well, the

dressings is re-applied; but, if there be evidences of inflammatory action, the cavity is again thoroughly irrigated and injection repeated. Of sixteen cases treated nine were cured in six days, three in twelve, one in fourteen, and one in twenty-three days. Two were lost sight of. He claims these advantages for this procedure: First, that it is safe and simple; second, in suitable cases a more rapid cure than by other methods; third, that the patient is able to go about during treatment; fourth, it leaves no tell-tale scar; fifth, it in no way interferes with any other surgical procedure if such seems advisable.

In my own practice, if efforts at abortion by means of compresses fail, I incise the bubo freely, remove all diseased tissue, flush with hydrogen peroxide, full strength, until effervescence ceases. The wound-cavity is then mopped out, packed with iodoform, and over this a dry bichloride gauze dressing confined by a firm spica. In patients who lead a sedentary life, the wound heals in from two to three weeks, with a barely perceptible scar.

As regards the treatment of syphilis, the fact that there is little new argues well for the present methods adopted in its management. Mercury and the iodides, singly or combined, are as popular as ever, and deservedly so. Properly and intelligently administered, there are but few cases that resist these remedies.

As regards the preparation of mercury used (*The Practitioner*), Hutchinson in a late article states his preference for the chalk mixture in the second stage. In ordinary cases he employs one grain of gray powder with sufficient opium to prevent diarrhea and griping. This he gives three or four times daily according to effect, the diet being carefully regulated. The iodides, he says, are very useful in gummata and affections of the nervous system. He uses the three iodides, potassium, ammonium, and sodium together, combined with a small quantity of free ammonium, which he thinks should never be omitted. For hereditary syphilis inunctions are the most effective. A solution of bichloride in small doses is well borne by infants and children, and is usually very effective. It is not so apt to purge as the gray powder.

Hebra treats his cases by the introduction of bichloride hypodermatically. $\frac{1}{2}$ to $\frac{3}{4}$ of a grain is injected, weekly, deep into the gluteus maximus muscle. If done aseptically abscess or ulceration never follows. I witnessed the efficacy of this method in the prompt disappearance of cutaneous lesions. I think well of the gray powder as used by Mr. Hutchinson, but prefer the proto-iodide pill, preferably that of Schieffelin & Company.

When I find anemia in the second stage, I have used with excellent results this formula :

R Hydrarg. bichlor., gr. ij;
Liq. ferri albuminatis (Flexner), ℥viiij.
Ft. solut. Sig: Dessertspoonful in water after meals.

We have here a palatable iron mixture which converts the bichloride into the soluble albuminate of mercury, a salt easy of assimilation. In late syphilis I substitute for the mercury potassium iodide with the iron as above, or in suitable cases the three combined.

That syphilis is fast losing its malignancy there is scarce a doubt in the minds of those who have traced the history of the disease from its earliest recognition, and I firmly believe that the future generation will see this once-dreaded malady and former scourge of mankind so far divested of its terrors as to be classed along with the other exanthemata.

LOUISVILLE.

LARGE CYST OF KIDNEY; NEPHRECTOMY; RECOVERY.*

BY L. S. M'MURTRY, M. D.

Professor of Gynecology in the Hospital College of Medicine, of Louisville.

The extension of the field of abdominal and pelvic surgery, and the splendid results attained in recent years, have become so familiar to the profession that isolated cases have ceased to be of special interest. The following case, however, is somewhat unique, and illustrates so many important practical points that I deem it worthy of special report and discussion.

On June 26th I was asked by my friend, Dr. Henry E. Pelle, to see a patient with him in the west end of the city. The patient is thirty-two years of age and unmarried, and presented the following history and symptoms: About three years ago she noticed an enlargement of the abdomen toward the left side. It gave her no discomfort at first, but she observed that it steadily increased in size. During the past year it had grown rapidly, and had now assumed the proportions of a large abdominal tumor, giving her abdomen the general contour and appearance of a woman far advanced in utero-gestation, except the tumor was larger toward the left side. Her general health was

*Read before the Clinical Society of Louisville, July, 1893.

excellent, except that she was losing flesh, and suffering more and more with pressure symptoms. During the past few months she had perceptibly emaciated, and was unable to eat a full meal on account of the discomfort following. Her activity was interfered with also, being unable to discharge her duties easily on account of the weight and pressure of the tumor. Physical examination of the abdomen disclosed the typical signs of a monocystic ovarian tumor. It occupied the general abdominal cavity as well as the pelvis, had pushed the uterus backward into Douglas' space, thinned the abdominal walls, and fluctuated distinctly upon percussion. All the symptoms were characteristic of a cyst. Abdominal dropsy was readily excluded. She had expressed her desire to Dr. Pelle for permanent relief, and he had made known to her the necessities for operative interference. She was at once placed upon preparatory treatment, and went to the infirmary to undergo the operation.

The operation was performed on July 3d at 9 A. M. Besides assistants and nurses, Dr. Pelle and Dr. R. C. Chenault, of this city, were present. A free incision was made in the median line between umbilicus and pubes, as in ovariectomy. On dividing the parietal peritoneum I was puzzled by finding another movable layer of peritoneum covering the cyst. My first thought was that it might be an ovarian cyst which had grown in the leaflets of the broad ligament so as to present such a duplicate fold of the serous membrane, but passing my two fingers down in front of the cyst into the pelvis I found both ovaries in their proper position, and quite normal in every respect. This demonstrated that the tumor had its origin in the post-peritoneal space, and had carried the peritoneum in front of it in its development. Following the outline of the tumor with my hand, I soon traced its attachments to the left lumbar region, and satisfied myself that I was dealing with a large cyst of the left kidney. Announcing this to the anesthetist, Dr. J. W. Guest, he immediately substituted chloroform for ether, which he had been using up to this stage of the operation, and continued to use chloroform throughout the remainder of the operation. Cystic degeneration of the kidney usually presents a large number of small cysts clustered together, and hydro-nephrosis, which is the result of an obstructed ureter, is limited for the most part to the pelvis of the kidney with varying degrees of renal structures preserved. This cyst, however, presented the pearly hue of an ovarian cyst, and, as the specimen presented herewith shows, consists of the capsule converted into a large single cyst. The capsule was distended and rendered very thin.

It was easily punctured with the trocar, and the contents emptied into the tub beneath the table. I presume that it contained about one gallon of clear serous fluid. After emptying the cyst I found quite a task presented in separating the sac from its attachments to the peritoneum of the left lumbar region, and in freeing it from the spleen, to which it was firmly attached, and which appeared as a cap to the tumor.

In separating the spleen, although observing the utmost care, I injured the capsule of that organ and denuded a considerable surface upon its inferior border. This started a capillary hemorrhage, which persisted throughout the remainder of the operation and for three days afterward. After freeing the cyst in all directions, I tied the ureter and divided it. I then secured the renal vessels with a strong silk ligature, ligating them in two parts, and cut away the cyst. I then closed with fine silk sutures the opening in the posterior layer of the peritoneum, through which I had delivered and removed the diseased kidney. An examination of the kidney on the right side at this stage of the operation demonstrated that it was of normal consistency, but very appreciably enlarged, which I attribute to the additional work thrown upon it by the progressive crippled condition of the other kidney. After cleaning the abdomen thoroughly and securing all bleeding points, I found the denuded surface of the spleen still oozing, and that the sponge packing I had applied had done little to arrest it. The bleeding was not great and not active, but consisted of a steady oozing of bright blood.

In order to deal with the pedicle and secure thoroughly the renal vessels, I had made a transverse incision in the abdominal parietes at right angles to the median incision, and extended this into the left lumbar region. I now closed the abdomen by suturing carefully both incisions, being careful to adjust accurately the severed rectus muscle end to end, and having placed a glass drainage-tube through the lower angle of the median incision, with the point resting in Douglas' space, where all oozing fluid would naturally gravitate, the usual dressing was applied, and the patient put to bed in good condition. There was no sweating or other symptom of shock, the pulse being 104 and of good volume.

The convalescence has been exceptionally easy and uneventful. The secretion of urine was quite free, and indicative of excellent kidney function. This has continued without interruption throughout her convalescence, and as it is evident from the specimen that all secretory tissue had long been destroyed in the diseased kidney, its fellow had

evidently assumed compensatory structural and functional activity. The drainage was quite free for the first twenty-four hours, the bright color of the blood showing that it came from the spleen. This gradually ceased, and the tube was removed on the fourth day. The pulse remained under 100, and the highest temperature recorded was 99.6° F. The large double incision united throughout by first intention, and the stitches were removed on the ninth day. As a precaution against hernia after such extensive incision of the abdominal walls, I have kept the patient upon her back, and will insist upon keeping her in bed for three weeks, by which time organization and consolidation of the incision will be complete. Her appetite is excellent, and all her digestive and eliminative functions seem to be carried on perfectly, which I interpret as an indication of good compensatory power on the part of the right kidney, and a guarantee of restoration to perfect health. This woman has naturally a strong constitution, has been accustomed to health-giving habits of frugality and industry, with temperate habits.

I herewith present for examination the sac of this large tumor, which in its lower part still retains an outline of the form of the kidney. The fluid contained in this cyst was not urine, but a perfectly clear fluid, such as we find in a typical par-ovarian cyst. It was an illustrative case of general cystic degeneration of the kidney, the capsule of the kidney forming a strong cyst wall, just as obtains in large ovarian cysts.

The practical lessons to be deduced from this experience are:

1. That in the diagnosis of abdominal tumors a large experience and painstaking investigation can not determine infallibly the exact character of even typical illustrations of ovarian tumors. The greater frequency of ovarian cysts alone determines a presumptive diagnosis between ovarian cyst and renal cyst. The exploratory incision is at last the means of positive diagnosis.

2. In operations presumably for simple, uncomplicated ovarian tumors the safety of the patient demands that the operator be qualified and prepared to deal with unexpected complications, and to do any operation known in abdominal surgery.

3. The results of nephrectomy, as shown by recent work, place this class of tumors within the limit of safe surgical procedures.

4. In dealing with large renal growths, and where nephrectomy may of necessity follow nephrotomy, the lateral abdominal incision in the semi-lunar line is preferable to the lumbar incision.

THE LIQUOR HABIT.

BY C. T. POPE, M. D.

In these days, when the curing of drunkards has loomed up into such prominence, my experience may be to some extent interesting, and at the same time the means of causing the profession to become more familiar with a remedy which, in my hands, has proven itself of much value.

For some time after the question of treating the liquor habit had begun to be agitated, I read numerous articles on the subject in both the medical and the secular press, but gave but little consideration to the claims made for the different cures (as they are called) until a patient came under my observation who, I thought, would make a good subject to experiment upon.

At about the same time my attention was called to the treatment recommended by Dr. S. H. Garvin, of this city, with whom I was personally acquainted, and who I knew had had ample opportunity to study the matter thoroughly. After a consultation with the doctor, I concluded to follow his advice in the treatment of my patient. The directions were: "Antidipsole" (as he calls his remedy), one teaspoonful six times a day. The meals—three a day—to be at stated hours, so as not to interfere with the medicine. Three warm baths a week, to be followed by a thorough rubbing-down with a coarse linen towel, to invigorate the skin, and rest in bed at least eight hours out of the twenty-four, to give repose to the nervous system. The result will be seen by a perusal of the case referred to, and also two others that came to me during the following three months:

CASE I. H. W., age forty-five, married, occupation at present clerk for a lumber merchant; was formerly a dealer himself, but dissipation caused his downfall, and for several years he had made only a bare subsistence for his family. When called to see him last October he was suffering from his fourth attack of mania-a-potu. As soon as he recovered, and was in proper condition, I put him on "Antidipsole." His anxiety to give up drinking prompted him to give careful attention to my directions, and in three days all desire for liquor had passed away—a condition he had not known since he became addicted to its use. He soon began to relish his food, and to sleep well, and by the end of the month (the time required for the treatment) he was completely restored, and

able to attend to business as well as ever. He has taken no intoxicating liquor of any kind since, nor has he had any desire to.

CASE 2. M. W., age thirty-eight, single, book-keeper by profession, came to me for medical advice last November. The object of his visit was to have me dress a broken nose, the result of a drunken broil. During the time he was coming to my office to have his nose attended I learned from him his history. According to his statement, he had been a constant and heavy drinker ever since he was twenty years old, and the rough usage he had received during his last spree had about determined him to let whisky alone for the future. At my suggestion to be treated for his bad habit he readily consented, and I immediately put him on "Antidipsole." His experience was similar to that of Case 1. The craving for alcholic stimulants left him in a few days; he regained his appetite for food, and after a week's treatment he informed me that he had, the night previous, slept eight hours without interruption—something he had not done before since he began the use of intoxicants. He is a sober man to-day, and making a good salary at his calling.

Case 3. I. L., age forty-three, married, by trade a tinner, a periodical drinker whose sprees were usually continued until terminated by an attack of mania-a-potu. In January last I was called to see him in one of these attacks, which was the winding up of a spree that had lasted for several weeks. On his recovery, by the request of friends, himself consenting, I took him in hand to cure him of the liquor habit. "Antidipsole" was given him in teaspoonful doses six times a day. His faithfulness in carrying out the treatment was remarkable, and the result was that he was soon so completely relieved from his thirst for stimulants that he had no farther trouble from that source. Like the preceding two patients, restoration to the normal condition was rapid, and after the termination of the treatment he was, as he expressed himself, in good health, and no longer a slave to "King Alcohol."

It is not my purpose in this paper to enter into a discussion on the pathology of alcoholism, nor to express an opinion as to whether inebriety is a disease or only a habit, but simply to add my experience, with a few brief comments to this much discussed question.

Referring to the cases cited, what has been accomplished by the treatment for these patients? First, the craving for stimulants has been overcome, and thus, by enabling the patients to discontinue the imbibition of alcohol, the emunctories have been given an opportunity to throw off the poison existing in the system, and allow the various

organs to perform their functions normally. The brain consequently being relieved, refreshing sleep was had, which rest resulted in more activity of that organ, and necessarily a brightened intellect. So with the digestive apparatus: food which before was only taken irregularly and in small quantities, was now called for and relished, and in turn gave strength and tone to the general system, so that the exertion necessitated by the requirements of a busy life, which, while the individual was under the influence of alcohol, was performed with difficulty, was now accomplished with comparative ease.

But this improvement in the health and condition of the patient, while largely due to, was not altogether the result of giving up the use of intoxicants and the elimination of alcohol from the system. The remedy did more than simply relieve the craving for stimulants, as can be readily seen from its composition as shown by the formula: *Lupulin*, *serpentaria*, *apium graviolens*, *cinchona*, *capsicum*, and aromatics. The *apium graviolens* and *lupulin* are most excellent nervous stimulants, the *capsicum* the best of stimulating tonics for the digestive organs; and the *cinchona* and *serpentaria* rank, as diversified tonics, among the first. Here we have just what is called for in the general debility caused by inebriety, and the rapid recovery from the exhausted state which marks this condition, the restoration to a healthy appetite, refreshing sleep, and a general feeling of comfort is undoubtedly due, in a great measure, to the direct action of the medicine, and not altogether to the discontinuance of the stimulant.

What constitutes a cure of the liquor habit is a pertinent question, and one which is difficult to answer. Let us go back and look over our cases, and see what has been accomplished. Case 1, H. W. drank to such an extent for several years that he had made but a bare subsistence for his family. Commenced the treatment October, 1892; has now been sober eight months. Case 2, M. W. had been a regular drinker for eighteen years. Commenced treatment last November—now seven months since he took a drink. Case 3, I. L., a periodical drinker who was seldom sober, has not drunk liquor since last January—five months.

These individuals have not only not used stimulants since their treatment, but they have no inclination to do so. Are they cured? I answer, most certainly they are; the treatment has restored them to their normal condition, which is all that can be accomplished by medicine, and it is with themselves only whether they will continue to abstain from alcoholic beverages.

All talk about cures that will cause one who has taken them to loathe liquor is the most perfect bosh, and is only given out to catch the gullible. If after treatment the individual has lost all craving for stimulants, and in point of health has been perfectly restored, has not enough pride to hold himself above temptation, he will drift back into his old habit, no matter who treats him, or how he is treated.

And now, in conclusion, let me say a few words in regard to the remedy, "Antidipsole." The combination of medicines for the condition for which it was formulated is certainly a very happy one, for while there is no doubt a large percentage of those who take it for the liquor habit will be cured, all will be benefited, and none can possibly be harmed, for nothing of a dangerous character enters into its composition—nothing that could possibly do injury.

LOUISVILLE.

Reports of Societies.

KENTUCKY STATE MEDICAL SOCIETY.

Thirty-eighth Annual Meeting, Frankfort, Kentucky, May 10, 11, and 12, 1893.

SECOND DAY, THURSDAY, MAY 11TH—MORNING SESSION.

Meeting called to order at 9:25 A. M.

The Secretary read a communication presented by delegates from the Kentucky Pharmaceutical Society.

On motion the report was received, and the delegates were invited to take seats in the meeting.

Dr. A. D. Price, of Harrodsburg, announced the death of Dr. C. H. Spillman, and moved that the following be given an appropriate place in the transactions of the Society:

IN MEMORIAM. Dr. Charles Harvey Spillman was born in Garrett County, Kentucky, May 20, 1805, received his collegiate education at Center College, and took his degree in medicine at Transylvania in 1835. He assisted in the organization of the Kentucky State Medical Society at Frankfort in 1851, was its president in 1854. He was an honored member of his profession, faithful to every trust, and respected by all who knew him. He died at Hopkinsville, December 15, 1892.

The motion was carried.

On motion of Dr. Lyman Beecher Todd the greetings of the Kentucky State Medical Society were sent to the State Medical Society of Indiana, then in session at Indianapolis.

On motion of Dr. W. L. Rodman, of Louisville, committee of one appointed last year by the Society to represent Kentucky, and to collect funds toward the erection of the proposed monument in Washington, D. C., to the memory of Dr. Samuel D. Gross, a committee of five was appointed to continue the work. The committee stands as follows: Dr. W. L. Rodman, of Louisville, chairman, Dr. Orin D. Todd, of Eminence, Dr. Fletcher, of Henderson, Dr. J. Q. A. Stewart, of Frankfort, Dr. C. H. Todd, of Owensboro.

Dr. J. W. Speer moved that the Society spread upon its minutes some tribute to the worth of Dr. J. W. Gilbert, of Lawrenceburg. Carried.

The Chair appointed Dr. J. W. Spear, Dr. B. F. Eager, and Dr. B. L. Coleman, who presented the following resolution:

Resolved, That in the death of Dr. J. W. Gilbert, of Lawrenceburg, Kentucky, the profession has lost one of its most useful and honored members, and the State Medical Society offers sympathy and condolence to his family and friends in their great bereavement. Respectfully,

J. W. SPEER,
B. F. EAGER,
B. L. COLEMAN.

Dr. A. D. Price offered the following:

Resolved, That the Kentucky State Medical Society endorses the beneficent and indispensable work being done by Dr. John Q. A. Stewart at the Kentucky Feeble Minded Institute, and the Society hereby urges the General Assembly to foster the interests of this unfortunate class by all needful legislation and appropriations.

Resolved, That the Secretary be requested to notify the clerks of both houses at once of this resolution.

Carried.

Dr. R. B. Gilbert, of Louisville, offered the following:

Resolved, That the legislature be memorialized that it was the sense of this body that they should pass the bill now pending before them legalizing the procuring of unclaimed bodies for dissecting purposes.

Carried.

Dr. J. N. McCormack, of Bowling Green, who last year offered the resolution given on page 5 of the Transactions of the 37th annual meeting, to wit, "that a committee of five be appointed by the Chair

to report to the next annual convention a plan for organizing a medical society in each county in the State as auxiliary to this Society, and so ordered that members of county societies as such shall become members of the State Society," said that he had been a correspondent for some time with a number of State medical societies which have had this work on trial or in progress in the State, and also with the secretary of the American Medical Association, and that he had collected considerable literature on the subject. The work is so important that the committee thought it had better not be put in form before the Society until more information had been obtained, and until it was seen how the work was progressing in other States. He therefore reported progress, and asked that the committee be given further time. The committee was continued.

Dr. L. S. McMurtry, of Louisville, called up the resolution introduced by him last year which provides "that the Constitution be so changed as to abolish the standing committees, and that in lieu thereof the Chair at the next meeting appoint a committee to select and arrange papers on medical, surgical, obstetrical, and gynecological subjects, and also gentlemen to lead in the discussions on the various papers presented." The resolution, which was seconded by Dr. Evans, looks to a change in the Constitution as relates to our order of business, and therefore had to lie over till the present time. It was recalled that the Society might have an opportunity to vote on the question.

On motion of Dr. McCormack the number of the committee was fixed at three, and the amendment adopted as proposed.

On motion of Dr. McCormack, Dr. A. H. Stewart, chairman of the Senate Committee on Public Health, and Dr. Johnson, chairman of the House Committee on the same subject, were invited to seats upon the platform.

Dr. Lyman Beecher Todd, of Lexington, read a paper on Cholera Infantum. [See page 497.]

DISCUSSION.

Dr. R. B. Gilbert, Louisville: The author says that this disease stands fifth in the rank of mortality in the diseases of the land; but strictly speaking that is not correct. It may be true as far as the tables of our mortuary reports are concerned, but cholera infantum is a cholera and not a diarrhea, and I take it that it is not an inflammatory disease, but rather a disease of hyperemia of the mucous membrane of the alimentary tract, and that the very moment that it passes into an inflammatory condition it is no longer

a cholera or choleric disease, but an inflammatory diarrhea, and the line ought to be strictly drawn there. The text-books on the subject do not make the distinction clear enough, neither do the profession as a rule. The summer of 1888 was very hot and dry, and there was a great deal of mortality from cholera infantum in Louisville, so reported. I examined the mortuary list and observed that out of 38 cases of alleged cholera infantum there were only 7 in which the duration of the illness was less than ten days. All those cases that lived beyond three or four days certainly became inflammatory diarrhea; some of the cases set down as being deaths from cholera infantum were tabulated as continuing for two weeks, and one even as long as three weeks. Now we all know that a disease of a choleric character characterized by copious, frequent serous evacuations, the serum being drawn directly from the blood through the follicles into the the alimentary tract, can not continue over thirty-six hours at the best. It is cholera infantum in the strict sense only during the time that the serous evacuations continue. Therefore the line should be drawn between inflammatory diarrhea and cholera infantum. If that were strictly done, cholera infantum would fall very low in the rank as a cause of mortality.

A word about the causes: There are several causes in operation that precipitate this disease. The debilitating influence of the hot season of the year is an important factor. It occurs mostly in the latter part of the summer season; noxious vapors from wharves and sewers are also a potent cause of cholera infantum; and indigestible food, which includes all the varieties of milk, etc., that are fed to infants. I know of one case in which a pickle caused a cholera infantum in two or three hours, which terminated fatally in from six to eight hours. Another cause that is not often spoken of (and one that we should look well to) is colostrum in the mother's milk. I have followed up several cases which seem to me to be clearly due to this cause. To illustrate with a case:

There was a lady visiting Louisville from Nashville; she had been there a month or more, and was in perfect health. She had an infant eight months old. Her husband came out to visit her the day following her arrival, when the child was attacked with cholera infantum in the early part of the day, a severe type at that, which terminated fatally in less than twenty-four hours. The question arose as to what could have caused this cholera infantum. It had had no food whatever except mother's milk, and therefore we had to trace the cause to the milk. On questioning the lady she acknowledged that during the night and morning she had received the sexual embraces of her husband three times, and immediately succeeding each sexual act the infant had been allowed to take the breast. Sexual excitement, if at all excessive, will produce more or less colostrum in the milk. A sample of this woman's milk, which I procured that same morning, was examined microscopically by Prof. H. A. Cottell, of the University of Louisville, and was found to contain an abundance of colostrum. Now I need not say that colostrum is indigestible. It is in the mother's milk at

the birth of the child and stimulates the alimentary canal, causing two or three evacuations at the start of life. Two other cases shortly succeeding the one reported were studied up and found to be due to all appearances to the same cause.

In the matter of treatment I can not agree with the essayist, because the pathology of the disease is now pretty well admitted to be neurotic rather than inflammatory; the nerves controlling the mucous membrane of the alimentary canal for the time being lose tone and thus allow this exudate of serum.

Dr. F. J. Yager, Campbellsburg: I think the paper is strictly abreast of the times. I have had, I suppose, five hundred cases of cholera infantum in my long life of practice. I believe that often too much is done in the treatment of this disease. I am satisfied that the employment of small doses of calomel have done more in my hands to relieve the symptoms in this disease than any other remedy. It is the sheet anchor in cholera infantum, and I make the assertion from my experience. If you allow too much accumulation you will kill your patient instead of saving him. Use calomel judiciously; it has an antiseptic influence; it stimulates all the the secretory organs of the system; it revives the liver; it braces the system strongly, and favors the natural performance of all the functions that protract and continue life.

Dr. Wm. Bailey, Louisville: I would call attention to the necessity, first, of the character of feeding in children, and ask that if possible all sources of irritation in the alimentary canal should be excluded. I think few of the cases reported are genuine cholera infantum. If any thing is to be done for the treatment of cholera infantum it has to be done within a very few hours, for beyond then it ceases to be cholera infantum, and is simply the so-called summer diarrhea. I want to mention distinctly that I disapprove of the so-called small doses of calomel, 5 grains, for the infant. I believe if calomel is used in these cases, it ought to be in one tenth- or twentieth-grain doses every few hours until one grain is used. I think this is the proper method.

I want to call attention and bear testimony to the successful treatment of such cases by means of hypodermic injections, and I would treat these cases as I do cholera morbus, or as we control many of the symptoms in true Asiatic cholera. In these cases there is no absorption from the alimentary canal, and very little medication in that line accomplishes any purpose. Every thing is from the blood-vessels outward and not inward, consequently going to the other side of the circulation. Therefore medicine thrown into the areolar tissue is the proper treatment. A hypodermic use of atropine is also of great value. Infantile life bears atropine wonderfully well. In children only a few months old I have been able to give almost adult doses of atropine combined with relatively very small doses of morphia. I have given to a child $\frac{1}{80}$ of a grain of morphia and $\frac{1}{150}$ of a grain of atropine, repeated two or three or four times in twenty-four hours,

making the adult dose of atropine, which is admirably well borne by children. This controls the phenomena of cholera infantum, which would terminate life perhaps in a few hours without such treatment.

In addition to minute doses of calomel the indications are for astringents, to arrest the flow of serum, just as a surgeon should ligate a vessel to prevent the flow of blood, so these vessels must be astringed, or the patient will die. I must emphasize the treatment of cholera infantum experimented with in the polyclinic in New York in 1885 and 1886 by Dr. Perry Watson. I was with him during that time. Some of the cases did remarkably well, but those which reached collapse did not do well; but when we use by mouth $\frac{1}{40}$ of a grain of morphine and $\frac{1}{400}$ of atropine it proved quite successful given with astringents.

Dr. A. D. Price, of Harrodsburg, read a paper on Infectious Diseases and their Prevention.

This paper was not discussed. It will appear later in the *American Practitioner and News*.

Dr. John Y. Oldham, of Lexington, read a paper on the Surgical Treatment of Trachoma. [See page 503.]

DISCUSSION.

Dr. J. M. Ray, Louisville: The surgical operation then is certainly the best. By its aid we can, in the course of a few weeks, do more in the treatment of granular lids than we can by local application in the form of cauterization or astringents in months. However, after granulated lids have passed through the acute inflammatory stage into the stage of atrophy, in which stage we have the so-called sequellæ to granular lids, the surgical treatment is out of the question. The treatment then should consist of antiseptic astringents and oleaginous medicaments to lessen the friction of the lids and lubricate the conjunctiva. The so-called surgical treatment of granular lids is confined entirely to the early stages, during the stage of hypertrophy, the acute inflammatory stage. I have seen a number of cases where it had passed in through this stage and have found on version of the lid that the conjunctiva was glazed, and passing through from the inner to the outer canthus I found cicatricial contraction. Surgical treatment here can do no good. Therefore, in order to be successful in the surgical treatment of granular lids, the operation must be done early and during the acute stage.

Dr. S. G. Dabney, Louisville: I should like to say a word about the mechanism of the operation. It is well known that when the cicatricial contraction has taken place expression will be no longer useful; it is well known that operations for other purposes are often indicated; but in these earlier stages, when operation for expression is useful, there have been a number of different devices employed. Some surgeons use a simple cut-

ting rod, in many places producing scarification, and rubbing in a solution of bichloride of mercury. Others prefer the Knapp forceps. In my opinion the use of the Knapp forceps is attended with the best results. I believe in the beginning too much was expected; the reports first given were too favorable in regard to the operative treatment of trachoma; as is frequently the case in new operations the pendulum swung too far in favor of the operation, and now we have learned what to expect and what not to expect. I believe, in the early stages, and even when some cicatricial contraction has taken place, an operation is frequently beneficial; the contraction in the *cul-de-sac* is in itself hardly a contra-indication to the operation. We often find a great deal of hypertrophy and remaining papules in the conjunctiva, and their expression hastens very much the result of the case.

Dr. T. C. Evans, Louisville: In regard to the use of cocaine in these operations for trachoma, I would state that it is a peculiarity of the trachoma or granulated lid that cocaine is not absorbed from the conjunctiva, and we get very little effect; a general anesthetic is therefore necessary in all such operations either in the first or second stages. I agree with the gentlemen who have already spoken, that the general profession has got an erroneous idea of the new operation, in that the belief is quite general that surgical means are followed by immediate relief. It is a very valuable operation, and almost indispensable; but we frequently see the results of it delayed for several weeks after the squeezing. Even in the more acute cases it is not immediately successful as seems to be rather the general impression, but we must wait several weeks for contraction to take place.

Dr. P. Richardson, Louisville: I have used both the incision, the scalpel, and Knapp's trachoma forceps. I can get equally good results from the forceps and from the scarifying process. Both produce the same result. Take granulated lids, whether we have trachomatous matter either in the tissue or in the conjunctiva, or excessive granulation, it simply sets up an acute inflammation in a structure where there was a low form, and this acute inflammation extends into the conjunctival structure itself, and pressure of the forceps produces a cicatrix in the conjunctiva, and we have the cicatricial tissue contracted to such an extent that it renders the conjunctiva bloodless. The procedure will therefore necessarily lessen inflammation and absolutely prevent granulation. Where we have scar cicatrix we can not have granulation, as there is no blood supply for nutrition. When we press out the trachomatous material with the forceps, we reduce bulk in the conjunctiva, and set up an active inflammation. It takes as a rule one to three months to get rid of an active or severe case of granular conjunctivitis, either by scarifying or by the forceps. It is absolutely necessary to anesthetize the patient, since cocaine is of no avail, from the fact that the tension is so great in the conjunctiva that the local anesthetic not being absorbed will not reach the terminal ends of the sensory nerves.

Dr. Oldham: I have used trachoma forceps with poor success, not at all flattering. I do not wish to leave the impression that my treatment has been pursued with the aid of cocaine; I agree that cocaine will not answer, and that a general anesthetic is much preferable.

Dr. E. E. Hume, of Frankfort, chairman of the Committee on Credentials presented the report, which recommended for membership a long list of new names.

A motion was then made that the Secretary be instructed to cast a ballot for the names as reported by the Committee on Credentials. Carried.

The Committee on the Selection of Papers and the Appointment of Members to Discuss Them consists of Drs. David Barrow, of Lexington, A. M. Cartledge, of Louisville, and H. K. Adamson, of Maysville.

[TO BE CONTINUED.]

Reviews and Bibliography.

Elements of Human Physiology. By ERNEST H. STARLING, M. D. (Lond.), F. R. C. P., Joint Lecturer on Physiology at Guy's Hospital, London, etc. With one hundred illustrations. 437 pp. Price \$2. Philadelphia: P. Blakiston & Son. 1892.

The author has endeavored to present in this small work, as clearly and briefly as practicable, the main facts of physiology that are of importance to the student of medicine. Histology has been relegated by the author to works on anatomy, and when describing special investigation he confines himself to the principles involved, rightly holding that an acquaintance with practical details can be acquired only in a laboratory course. By this course he has been enabled to present the most valuable truths of physiology without such condensation as to render them obscure.

We have rarely met a work on physiology where so much satisfactory knowledge may be gained in so small compass.

D. T. S.

Text-book of Ophthalmology. By ERNEST FUCHS, M. D., Professor of Ophthalmology in the University of Vienna. Translated by A. DUANE, M. D. New York: D. Appleton & Co.

It will be a pleasure to many to know that Prof. Fuchs' book has been translated and is now accessible to those who were unable to read the original. While the translation seems to be good, the book will never be popular with students, since the text is often vague and the style strained; but to specialists who are particularly interested in ophthalmology it will be

often consulted, for no book is more thorough in its etiology and pathology. Prof. Fuchs has added to his reputation as an original investigator, especially in the chapter on Diseases of the Conjunctiva. While he gives but little space to treatment, he thoroughly considers these diseases from the standpoint of pathology. For trachoma he still uses cauterization, and pays but little attention to modern surgical methods.

The chapter on refraction is not what the modern American student of ophthalmology would find useful. The editor has added an appendix giving illustrations of the instruments usually required in ophthalmic surgery.

J. M. R.

Foreign Correspondence.

LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

Bees and Rheumatism ; An Eccentric Patient ; The Proposed Epileptic Colony ; A Case of Congenital Hernia ; Professional Poisoning in India ; The Treatment of Over-exertion ; Uremia in Pregnancy ; Hydrophobia at the Cape ; From Hospital to Consulting Rooms.

Some two years ago an Austrian physician advanced the theory that persons who have been stung by bees enjoy an immunity from the effects of bee-stings for varying periods, and that moreover a variety of the bee-sting is an infallible remedy for acute rheumatism. The latter part of the theory has received confirmation from a custom of the country people in Malta. Bees are plentiful in the island, and bee-stings are in such repute as a cure for rheumatism that resort to this primitive method of inoculation has been a common practice in severe cases for generations, the results, it is said, having been most satisfactory to the patients.

A man has been admitted into one of the hospitals who had set himself the task of swallowing some two hundred and fifty fruit stones. Having finished the meal he experienced excruciating pain. While under treatment on the first day in the hospital the medical men succeeded in removing two hundred plum stones. The man had taken all this trouble to place his life in jeopardy for a wager of five shillings.

Steps are still being taken to establish a home for those necessitous epileptics who are able and willing to work ; it is pointed out that there are nearly 78,000 epileptics in Great Britain, and 39,000 of these are still in the full possession of their reason. It is suggested that an estate of 100 acres, within fifty miles of London, be secured, and upon it an appropriate set of buildings be erected. The occupation provided will be farm and garden

work, which is at once easy and healthy. Patients able to pay will be also admitted, and it is hoped the colony would soon be self-supporting.

At the recent meeting of the Clinical Society Mr. Bruce Clarke produced a boy from whom he had removed the cecum and vermiform appendix, along with two inches of the large and two inches of the small intestine, on account of an irreducible hernia. The testicle was found to be so firmly adherent to the scrotal wall and to the vermiform appendix that it also had to be removed. At the time the boy was shown to the members of the society he was perfectly well, and there was no trace of the former congenital hernia, although it was upward of twelve months since Mr. Clarke had performed the operation. The edges of the wound in the intestine were joined by a double row of continuous sutures, and Mr. Clarke strongly drew attention to the fact that sufficient gut must be excised to insure healthy sections alone being brought together. He considered the adhesion of the testicle to the cecum had taken place *in utero* as the result of inflammation, and the hernia had consequently been caused by the testicle dragging upon the cecum in its endeavors to descend.

According to the report of the analyst to the Bombay Government on the cases of criminal poisoning during the past year, arsenic is the agent most commonly employed, for it is the cheapest and most easily obtained of deadly drugs; opium comes next, and then, much lower down in the scale, strychnia and pounded glass. The arsenic cases are said to be typical of the people among whom they occur. In a Scinde district a stranger went into a shop one day and entered into a friendly conversation with a man he met there. On parting, by way of thanking him, the stranger presented him with some sweets for distribution among his friends. The result was that five men and a boy were poisoned, and the obliging stranger has never been heard of since. It appears that the poison is usually given in sweetmeats, and generally by a "strange woman," whom the victims have met in the street, and who disappears. This "strange woman" is found in page after page of successive analyst's reports for the past twenty years, and under much the same circumstances. The Indian professional poisoner is said to be rarely caught, and usually not even suspected. In a large proportion of cases the crime is apparently without motive. Accident is the cause of discovery in the reported cases, for in remote villages a person dies and his body is buried before the suspicion of foul play gets abroad. It is also generally known in India that cases of arsenical poisoning disappear when the body is buried. The government analyst says that pounded glass is going out of use, because it is not always fatal, and more deadly poisons are cheap and can be obtained easily by any one. As a rule, it is administered by women to their husbands; they take off their glass bangles, reduce them to powder by pounding, and then mix them with various articles of food.

Dr. D. I. Leech, Professor of Materia Medica and Therapeutics, Manchester, has been selected this year to deliver the Croonian Lectures before the Royal College of Surgeons. The subject is the Physiological Action and Therapeutics of the Nitrites and Allied Compounds.

Dr. Dukes, the medical officer to the Rugby School, considers that, instead of the administration of brandy in the treatment of cases of over-exertion, bleeding is better calculated to relieve the faintness and respiratory embarrassment which characterize these attacks. He says that the vomiting, which in nearly all cases is associated with this condition of collapse, should be encouraged by the administration of warm water followed, if necessary, by the employment of artificial respiration and friction of the extremities. Alcoholic stimulants may be administered later.

Dr. W. Travers recently had under his charge a woman, aged thirty-one, who within a few days of the full term of her third pregnancy was taken with acute uremia. The urine was practically totally suppressed. Eight ounces of blood was at once removed from the arm, followed by immediate improvement in all the symptoms. The following day delivery was easily and naturally performed; the patient for twenty-four hours continued in a precarious condition, but subsequently made a complete recovery.

It is a somewhat curious fact that hydrophobia is unknown in the British South African Colonies, although there are, in addition to innumerable native canines, large numbers of every breed well known in Europe. The Cape Government have been repeatedly urged to impose quarantine upon new arrivals, as is done in Australia and New Zealand, where hydrophobia was once quite unknown. Nothing definite was done, however, until there is a report that the disease has been observed in Cape Colony, and the government have for the present forbidden the introduction of dogs from England. Steps are being taken to stamp out the disease.

A book, stated to be a medical autobiography by a graduate of London University, and entitled "From Hospital Ward to Consulting Room," is attracting some attention in student circles. It is the tale of one who has worked from a condition of poverty, commencing as an unqualified assistant, through various grades, until at the close of life he has attained ease and affluence. The author thinks that any man with ordinary intelligence can, by continuous and persistent labor, qualify himself for the highest pinnacles of the profession of medicine or surgery.

LONDON, May, 1893.

ARTIFICIAL RESPIRATION.—Laborde has experimented with a method which he considers a substitute for artificial respiration in cases of asphyxia due to drowning, or from any other cause. He calls it traction of the tongue. The tip of the tongue is seized and pulled upon rhythmically, imitating the rhythm of respiration. It has been tried with success in cases of drowning and of sewer-gas poisoning, also in the laboratory upon animals. His explanation is that it acts reflexly upon the superior laryngeal nerve, or some other nerve in that vicinity. He has found it also very useful in cases of simple syncope.

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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REMARKABLE SURGERY.

A case of sacro-iliac disease with immense distension of the abdomen with pus, with laparotomy and cure, is reported by Dr. Emory Lanphear, in the June number of Lanphear's Kansas City Medical Index, as having occurred in his practice, that certainly surpasses any thing else reported in the history of surgery. The patient was a little girl eleven years old, with the abdomen largely distended with tuberculous pus. The inner portion of the sacrum and ilium was a mass of tuberculous tissue. The outer plate of these bones, however, was sound except that at one point over the sacro-iliac junction a little dark spot peered through the periosteum on the outside. Dr. L. had the good fortune to cut down upon and find this little spot after a search of ten minutes, and having penetrated the bone with a probe and found pus within, he removed the outer plate of the bone almost unaffected, and scooped out a tuberculous mass constituting the inner portion. Less pus was found than would account for the conditions, so Dr. L. "determined to push onward even at the risk of going into an uninfected peritoneal space. So the parts were carefully washed with peroxide of hydrogen, bichloride solution, and hot water, and then the dressing forceps forced through the tissues lining the pelvis. There followed a gush of pus that *deluged patient, table, operator, and assistants*—many pints." The cavity was then explored with dressing forceps, the point of which "could be plainly felt through the atten-

uated abdominal wall and at places far distant from the entrance, near the umbilicus, in the pelvis, and over in the opposite inguinal region." The report that the point of the forceps came out at the back of the neck also, is not authorized.

The patient, notwithstanding strictly orthodox antiseptic treatment, did badly, the temperature ranging at irregular intervals from subnormal to one hundred and five degrees. The reason was that the little patient would persist in lying on her belly. Obviously the thing to do was to rip open the offending member, and reasonably, for many a belly has been cut open for less offenses. Well, a large incision (about four inches) was made in the abdominal wall, parallel with Poupart's ligament. The inner part of the sacrum and ilium were found much more extensively diseased than could be determined from behind, so that another mass of diseased tissue had to be curetted away from the inner side of these bones. Dr. L. then scraped away the "pyogenic membrane," and notwithstanding the loss of bone and the pyogenic membrane, which was presumably the limit of the abscess cavity, he found this "*already much smaller than at the first operation.*" Evidently it had filled up in anticipation of the good treatment to come. But the difficulties were not yet overcome. "An extra hard pull on the curette cut the internal iliac artery, and instantly the bright arterial blood began to fill the cavity and overflow." Dr. L. fortunately succeeded in getting his finger on the common iliac and arresting the hemorrhage, but when the blood was cleared out he "found the hole so deep and so dark that he did not feel like attempting ligation." So he carefully and snugly packed the whole cavity with iodoform gauze. This rupture of the internal iliac was so close to the common iliac that the stump could not be ligated, and it would have been necessary to apply the ligature to the common iliac.

"Progress was now rapid and uninterrupted." In a few weeks she was about the hospital on crutches, and she is "fat, rosy-cheeked, and jolly." No account is given of her dismissal from the hospital, though "for many weeks now the wounds have been healed," it being presumably the custom of the Kansas City hospitals to retain their patients until many weeks after they are well. In calling attention to this case we do not wish to excite the envy of our readers in foreign countries, neither to arouse their incredulity; more than all, we do not desire to discourage them. They must make allowances for soil and climate, and not expect such results everywhere. If, therefore, our kind read-

ers in Europe, India, Japan, and South America, and even he of our lone exchange at Cape Town, in Africa, fail to find in their experience similar cases, let them not be disposed to doubt the accuracy of American reports, but let them reflect that such vitality in the human frame and such skill in surgery is possible only where the longest river in the world overflows and manures its banks with its peculiarly rich alluvium.

D. T. S.

Notes and Queries.

THE DIAGNOSIS OF LOVE.—Dr. James Finlayson, in an historical review of Herophilus and Erasistratus, quotes a story from Plutarch concerning the latter. Antiochus, son of the King Seleucus, fell in love with his step-mother, the young and beautiful Stratonice. His condition was extremely unhappy. He made the greatest efforts to conquer his passion, but they were of no avail. At last he resolved in his despair to rid himself of life by neglecting all care of his person and abstaining from food; for this purpose he made sickness his pretense. Erasistratus easily discovered that his distemper was love, but it was difficult to conjecture who was the object. In order to find it out he spent whole days in his chamber, and whenever any beautiful person of either sex entered it, he observed with great attention not only his looks, but every part and motion of the body which corresponds most with the passions of the soul. When others entered he was entirely unaffected, but when Stratonice came in, as she often did, either alone or with Seleucus, he showed all the symptoms described by Sappho, the faltering voice, the burning blush, the tumultuous pulse, and at length, the passion overcoming his spirits, a *deliquium* and mortal paleness.

Erasistratus concluded from these tokens that the prince was in love with Stratonice, and perceived that he intended to carry the secret with him to the grave. He saw the difficulty of breaking the matter to Seleucus, yet depending upon the affection which the king had for his son, he ventured one day to tell him "that the young man's disorder was love, but love for which there was no remedy." The king, quite astonished, said: "How! love for which there was no remedy!" "It is certainly so," answered Erasistratus, "for he is in love with my wife." "What, Erasistratus!" said the king, "would you who are my friend, refuse to give up your wife to my son when you see us in danger of losing our only hope?" "Nay, would you do such a thing," answered the physician, "though you are his father, if he was in love with Stratonice!" "O my friend," replied Seleucus, "how happy should I be if either God or man could remove his affections thither! I

would give up my kingdom, so I could but keep Antiochus." He pronounced these words with so much emotion, and such a profusion of tears, that Erasistratus took him by the hand and said: "Then there is no need of Erasistratus. You, sir, who are a father, a husband, and a king, will be the best physician too, for your family." Upon this Seleucus summoned the people to meet in full assembly, and told them it was his will and pleasure that Antiochus should intermarry with Stratonice, and that they should be declared King and Queen of the Upper Provinces.

For the cure of the young prince Erasistratus is reported by Pliny to have received a fee of 100 talents, which is calculated as amounting to more than one hundred thousand dollars.—*Boston Medical and Surgical Journal*.

FORD'S THEATER.—The building in Washington that was formerly Ford's Theater, but was for several years used by the Medical Department of the army, collapsed recently, while five or six hundred employes were at work there, killing about twenty-five and wounding many more. The building was the one in which President Lincoln was assassinated in 1865. For reasons of sentiment it was not torn down as it should have been, when it was taken for the Medical Department, but was more or less remodeled. For several years it was used for the Medical Museum and Library of the Surgeon-General. Not long ago the museum and medical library were transferred to a special building connected with the National Museum. Then the theater was made an overflow building for the Record and Pension Bureau of the War Department. An immense mass of military records, which are searched for the evidence of service of every applicant for a pension, must have been transferred to it, and the repairs which the building was undergoing when it collapsed were probably required to make it adequate for its latest uses.

Special Notices.

Pepsin is undoubtedly one of the most valuable digestive agents of our *Materia Medica*, PROVIDED A GOOD ARTICLE IS USED. ROBINSON'S LIME JUICE AND PEPSIN, AND AROM. FLUID PEPSIN, (see page — this number) we can recommend as possessing merit of high order.

The fact that the manufacturers of these palatable preparations use the purest and best Pepsin, and that every lot made by them is carefully TESTED, before offering for sale, is a guarantee to the Physician that he will certainly obtain the good result he expects from Pepsin.

INFLAMMATORY RHEUMATISM.—Dr. W. V. English, of Keokuk, Iowa, reporting on a case of this nature, writes: During the past winter a remarkable case of inflammatory rheumatism came to my attention, which was remarkable for its persistency in constantly growing worse while under the lines of well-established treatment. Not a whit of encouragement came from the treatment until the patient was confined to Tarrant's Seltzer Aperient as a neutralizer of the cause. Success complete crowned the effort. It is a sensible treatment, including the principles of whatever therapeutic means one would employ.

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Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

TUMORS OF THE NECK.*

BY W. L. RODMAN, M. D.

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No region of the body is so prolific in neoplasms as the neck. No region of the body is so important from an anatomical and surgical standpoint, containing as it does many great vessels and nerves, the integrity of which is essential to life. Therefore the diagnosis and treatment of morbid growths in this situation is of commanding interest. Never passed the time, since surgery has been practiced as an art, that its followers everywhere have not approached operations upon the neck with the greatest caution, if not trepidation. While a proper amount of anxiety should attend all operations in so vital a spot, I shall endeavor to show that the danger incurred in the removal of tumors from the neck varies as widely as the many neoplasms differ histologically.

Tumors superficial to the deep cervical fascia are comparatively easy of diagnosis and safely operable, presenting no greater danger than similar growths in other regions of the body. The only vessel of importance is the external jugular vein, and this can usually be avoided; as it is a prominent landmark in the neck the danger from cutting it is not great. I have twice wounded it myself, and have seen others do so without trouble. Tumors originating beneath the deep cervical fascia, on the other hand, present the greatest difficulties in

*Read at the May meeting of the Kentucky State Medical Society, 1893. For discussion see p. 28.

their diagnosis and removal. Tumors of the neck are common at all ages. They are congenital and acquired, cystic and solid, benign and malignant. This region is pre-eminently the site of congenital cysts, and I know of no other which compares to it in this respect.

Many tumors which are usually thought to be acquired are congenital, being held down by the deep fascia, and prevented from appearing externally. A congenital cyst may not form a distinct and well-outlined tumor until adolescence or middle age. This knowledge is of great value in diagnosis and treatment.

Cysts as they occur in the neck embrace almost every known variety.

1. The simple, serous, or unilocular cyst is frequently met with in the subclavian triangle, and may pass downward under the clavicle into the axilla or chest. They contain, as a rule, a colorless, limpid fluid, and are usually called "hydroceles of the neck." This cyst is congenital or acquired, and may be above or beneath the deep cervical fascia. It is usually translucent and covered by smooth, thin skin of natural color. The aspirator would settle the diagnosis in any doubtful case. These cysts are supposed to grow from the branchial clefts, and have been accurately described by Maunoir, Phillips, and others.

Treatment. When practicable they should be excised. When deeply attached it will be better to excise a portion of the cyst wall, drain freely, and plug with iodoform gauze. The old treatment of tapping and injecting with iodine, carbolic acid, etc., is uncertain and dangerous. Setons are more so. Spontaneous recovery has followed accidental rupture.

2. The second variety of cyst encountered in the neck is the compound or multilocular, the cystic hygroma of some authors, the lymphangioma cysticum of others. It is generally congenital, and develops from the lymphatic vessels. It is most obnoxious to the carotid triangles. The different compartments of these cysts vary in size from a small shot to an orange. Their contents vary as widely as their size. Every sort of fluid, semi-solid, and solid material may be found in them. They are usually situated beneath the deep fascia, but may perforate it and present superficially. They are attached to every thing, vertebræ, muscles, vessels, and nerves, which makes their removal always a serious matter, often an utter impossibility. No other treatment, however, is at all satisfactory, and most authors recommend excision with all its primary and secondary dangers.

The internal jugular vein, carotid artery, and pneumogastric nerve have been excised in removing these growths, the patients in some instances making excellent recoveries. They are recognized by their tuberculated outline, fluctuation, and preference for the carotid triangles.

3. The bloody cysts or hematoceles may be met with in the neck. Sometimes they are hydroceles into which a vessel has ruptured. There is, however, a true bloody cyst intimately connected with the great vessels. Their contents resemble blood, and it is said that they are cyst-like dilatations of the internal jugular vein. They may or may not communicate with the interior of the vessel. Subsidence of swelling upon gentle pressure would be an evidence of such communication, and a useful hint as to treatment as well.

4. Sebaceous cysts are frequently met with in the neck. They are superficial and deep, usually the latter, as pointed out by Von Langenbeck, differing in this respect from similar cysts in other parts of the body. Superficial sebaceous cysts are likely to occur in the thyrohyoid region, and are easily enucleated. They may attain the size of an orange. Deep epidermic cysts are, according to Gross, invariably situated in the superior carotid triangles, usually the left. They are frequently connected with the sheath of the vessels, and when the head is in certain positions pulsate synchronously with the heart. They give a pulpy fluctuation, which is best elicited by putting one finger in the mouth and the other over the tumor. Von Langenbeck advises extirpation with all of its risks and hazards.

5. Bursal cysts, developed from the two normal bursæ situated along the middle line of the neck, are infrequently found. The upper bursa is found between the hyoid bone and thyroid cartilage, the lower and larger one between the thyroid cartilage and skin. Those tumors are diagnosticated by their situation, viscid contents, and obedience to the movements of the larynx. They are rarely so large as a walnut.

6. Hydatid cysts have in rare instances been found in the neck. Erichsen reports two cases, one removed from the subclavian triangle of a woman upon whom he had previously operated for hydatids of the liver.

7. Along with cysts may be mentioned the air cyst or goitre aerien. It is caused by a hernia of the mucous membrane of the larynx or trachea through their cartilages or rings respectively. They disappear upon pressure, vary with respiration, and enlarge after exertion. It is

a rare affection, and occurs in those who use the voice constantly, as the auctioneer or public crier.

8. Thyroid cysts are less common in America than in the mountainous regions of Europe and India. They are particularly common in the Alps and Himalayas. I have seen several well-marked thyroid cysts here in Kentucky. These cysts, which are usually multiple, generally affect the lobes of the thyroid gland, rarely the isthmus. The right lobe more commonly suffers, which will place these tumors in the right inferior carotid triangle. The cysts vary in size from a pea to a fist, and contain different kinds of fluid, rather viscid, bloody, with an abundance of cholesterine. They obey the movements of the larynx. Women suffer more frequently than men. The trachea may be pushed well to the opposite side.

Treatment. If the disease is limited to either lobe, the proper treatment is by excision. Prof. Kocher, of Berne, who has lived for years in a goitrous district, and has excised the thyroid gland, in whole or in part, far in excess of other surgeons, is emphatic in his approval of partial thyroidectomy, but condemns removal of the entire gland. Myxedema follows the latter operation in nearly every instance. He followed his cases carefully, and in only two out of eighteen complete thyroidectomies were the symptoms of myxedema wanting. In both of these the bronchocele returned, and it is fair to assume that he did not remove the entire gland. Of twenty-eight partial thyroidectomies, the general health of the patients did not suffer in any. The experience of other surgeons has been not unlike Kocher's, and few, if any, advise total extirpation of the gland. If a portion of it is left, the distressing and fatal symptoms of myxedema do not occur. Where excision is not practicable, incision and drainage should be followed. Tapping and injections, while curative in some instances, are, on the whole, more dangerous and less certain than incision.

The other enlargements of the thyroid gland may as well be disposed of now. Benign tumors do not affect the thyroid, and the only innocent affection of a solid nature to which it is liable is the fibrous bronchocele. It is simply an hypertrophy of the normal glandular and connective tissue. It may affect the entire gland, but, like cystic disease in this situation, is most obnoxious to its lobes, especially the right. The isthmus rarely suffers alone. Circumscribed hypertrophic conditions of this gland are by some called adenomata. Enlargements of this body in goitrous districts are frequently associated with cretinism

or idiocy. *Per contra*, idiocy, so far as I am advised by the Superintendent of the Feeble-Minded Institution of this State, does not predispose to enlargements of the thyroid. Malignant disease, carcinoma, and sarcoma rarely affect the thyroid. Cancer is by far the more common affection, and may exist as encephaloid or scirrhus. It appears late in life.

Treatment. Nothing can be done for malignant disease. The only hope would be in complete removal of the gland, and this is certain to be followed by myxedema. The solid bronchocele should be excised under the same rules governing operations for cystic disease. In very exceptional instances there may be accessory thyroids in the neck, within the larynx, trachea, etc., and they give rise to the same enlargements peculiar to the normal gland. Benign solid neoplasms are found in all parts of the neck. The most usual growths are lymphoma, enchondroma, fibroma, and lipoma. There is besides a local hypertrophic condition of the skin which at times is so distinct as to give the appearance of a tumor. The vessels in the affected area are much enlarged. This is really a *nevroid* condition.

Lymphomata are the most common of benign growths. They will generally be found in the submaxillary, occipital, and subclavian triangles. One gland is, as a rule, affected. Enchondroma is practically limited to the submaxillary triangle, where it affects the submaxillary salivary gland. I have never seen it in any other region of the neck. Fibromas are not specially common, and where they occur do so indifferently. No region is specially liable to them.

Lipoma or fatty tumor, while not frequent, is sufficiently common in the neck. They are very generally superficial to the deep fascia, and when so are easy of removal, whatever their size. My belief is that they are more commonly situated in the inferior carotid triangles than other parts of the neck. They may attain an enormous size, as shown by the photographs which I pass around, kindly sent me by my friend Dr. Samuel Swope, of Marion, Ky. Each had grown from twenty to twenty-five years.

Sterno-Mastoid Muscle. There is a circumscribed swelling of the sterno-mastoid muscle which is at times so pronounced as to give decidedly the appearance of a neoplasm. Bryant and Holmes, who have specially investigated the subject, speak of it as though it were peculiar to the new-born infant, and due to some injury during parturition. They are more common in breech presentations. It unquestionably occurs

in adults. I have seen two well-marked examples of this affection. Three years ago a farmer, about fifty-five years of age, living in Indiana, presented himself at the surgical clinic of the University with a well-marked circumscribed swelling in the right mastoid muscle. No history of syphilis or *trauma*. The muscle could be lifted up sufficiently to clear up any doubt as to diagnosis. This man was given iodide of potassium, blistered locally, and was practically well within a fortnight.

Malignant Tumors. Malignant disease of the neck may show itself in at least three different varieties. There are sarcomas, carcinomas, and the local enlargements incident to Hodgkins' disease, or, as we prefer to call it, lymphadenoma. Sarcomata are more frequent than carcinomas. Cancer never begins in the lymphatic glands primarily, and sarcoma does so but rarely. Both sarcoma and cancer are, in my judgment, usually found after forty, and are likely to be situated in the occipital or submaxillary triangles. Sarcomas give a most deceptive sense of fluctuation when well advanced. The skin is discolored a deep red or violaceous hue, and in time ulcerates. Hemorrhages take place from time to time, and aid in hastening the end. Sarcomas attain an enormous bulk.

Treatment. Unless seen and diagnosticated early, these cases are, in my judgment, not operable. No operation for malignant disease promises success unless considerable tissue can be sacrificed. This can not be done in the neck. These growths are always more adherent than they seem to be, are exceedingly vascular, often accompanied by enlarged glands, which renders their complete removal a matter of impossibility.

The primary and secondary dangers are so great from operations for the removal of these growths that the wise surgeon will, as a rule, decline to interfere, for at best he has little prospect of doing substantial good. Lymphadenoma affects the lymphatic glands of the neck early in the disease. The diagnosis of this affection can only be confounded with tubercular adenitis. As a rule, no trouble should be experienced in differentiating between them. Tubercular glands always begin in the submaxillary triangle, whereas in lymphadenoma the enlarged glands are first seen in the carotid and subclavian triangle.

Tubercular glands are, as a rule, small and unilateral; in lymphadenoma, larger and bilateral. Tubercular glands often break down;

lymphadenomata rarely do so. Above all, tubercular glands are most common between ten and thirty years of age; lymphadenoma occurs at any age, and men are more liable to it than women. Tubercular adenitis runs a chronic course, lymphadenoma an acute one. Surgery promises but little in lymphadenoma.

Tubercular Glands. No paper upon tumors of the neck would be complete without a description of the most common of all swellings in this region, tubercular lymphatic glands. While these growths are inflammatory, and not neoplastic in origin, still their history and operative treatment so closely resemble neoplasms that clinically we treat them as such. They are most common between ten and thirty years of age. The African and mulatto are very liable to them. They are unquestionably due to the tubercle bacillus, which gains entrance through a lesion of the skin, mucous membrane, socket of carious teeth, etc., and then carried by the lymph-vessels to the nearest lymphatic glands and deposited in their interior. The first glands affected are almost invariably the submaxillary. At first a single gland is enlarged. Later on, when it is no longer able to filter out all tubercle bacilli, they pass on to the neighboring glands, and so on possibly until the entire chain in this region, superficial and deep, become implicated in the tubercular process. So that we have first the submaxillary glands enlarged, next the occipital, lastly the subclavian. These all belong to the superficial chain. The deep lymphatic glands are situated immediately beneath the sterno-mastoid muscle, from its origin to its insertion. These, in part or in whole, sooner or later join in the tubercular inflammation.

In an advanced stage of this affection every gland on one or both sides of the neck may be enlarged. It may run an acute, subacute, or chronic course. Death may follow from miliary tuberculosis within a few months, or the disease may remain localized in a single gland for many years. The lymphatic glands are truly the "watch dogs of the system," and it depends upon how well they do their work what is to be the fate of the individual. As long as infection of the tissues, especially the lungs, is prevented, the disease runs a safe course. The capsule of the gland aids materially in localizing the germs and spores, and preventing infection of the surrounding paraglandular tissue. Separate for a time, tubercular glands usually fuse together, moving as a whole, the outlines of each, however, being usually distinct. The first infected are the largest, possibly attaining the size of a walnut, while those in-

volved late in the process are no larger than a pea. Tubercular glands may become caseous or break down. Those first affected are most likely to do so, but they do not suppurate in a literal sense. The fluid or so-called pus is sterile. Sometimes an acute process is engrafted upon the chronic, these glands becoming affected secondarily by the ordinary pyogenic organisms. Then true suppuration occurs, and the glandular tissues and tubercle bacilli are destroyed by the acute process which ends in abscess and drainage, a fortunate ending, where only one or two glands are involved. Acute suppuration taking place in a large number of glands could only hasten death.

Treatment. If modern bacteriology and pathology go for any thing, we should not be in doubt as to the treatment of tubercular glands in the neck or elsewhere. Exposure of the diseased parts by a free incision, so that each gland can be seen, felt, and completely extirpated, along with its capsule, constitute the ideal treatment. Where it is practicable, Senn advises, and I think wisely, that the entire chain of diseased glands should be removed *en masse*. An incision from the mastoid process to the angle of the lower jaw, and thence along its lower border, would give free access to the glands usually enlarged. Senn removes the submaxillary salivary gland, if it is at all suspicious; also the lower portion of the parotid. The occipital and subclavian glands are easily reached and enucleated. If the deep chain of glands situate beneath the mastoid muscle are to be removed, one or two plans are open to the operator. An incision along the anterior or posterior edge of the mastoid may be made in order to gain access to the diseased glands. The fact that the carotid artery and internal jugular vein have been injured in so many cases is sufficient evidence to me that these incisions do not sufficiently expose the parts, and the surgeon depends entirely upon the sense of touch. Billroth cut the jugular vein sixteen times in one hundred and twenty-eight operations. So that the operator shall see and feel every enlarged gland, the sterno-mastoid should be cut across about its center, and each end reflected back. Afterward the muscle should be sutured with over-prepared catgut or buried sutures of iron-dyed silk. The head should be held in one position to facilitate union of the ends of the muscle.

The results of Billroth, Frankel, Schuell, and others who have done many operations for tubercular glands, are quite as encouraging as an optimist would expect. About twenty-five per cent of the cases operated upon suffer relapses, and require a second and third operation.

When we remember that enlarged tubercular glands threaten life as long as they remain in the body, each being a focus for subsequent infection, and that in at least one case out of every eight miliary tuberculosis of the lungs follows, who can doubt what his duty is when a case of this kind comes to him for advice?

LOUISVILLE.

REPORT ON OTOTOLOGY.*

BY T. C. EVANS, M. D.

To make an intelligent and satisfactory report on the progress of Otology, impartially reviewing the literature of the entire field, giving to each author due credit and to each operation or therapeutic measure its proper place in the scale of importance, discriminating between what is original and what is repetition, without prejudice or favor, and still confining the report within bounds commensurate with the time and patience of a body composed almost wholly of general practitioners, would, indeed, be a difficult task. I shall, therefore, beg leave to confine my report to a single feature of the subject, that of intra-tympanic surgery. This embraces the various operations devised and employed for the relief of impaired hearing, for the relief of tinnitus, for cure of chronic discharges from the ear which have resisted treatment by non-surgical means.

During the year valuable and exhaustive articles on this subject have been contributed by Blake, Dench, Jack, Richardson, Randall, Wurde-mann, and others. Removal of the Stapes (Clarence J. Blake, Archives of Otology, Vol. XXII, No. 1): Blake advocates the use of cocaine in middle-ear operations, in view of the fact that it affords an opportunity for diagnosis by elimination, that it permits the performance of the preliminary incision of the membrana tympani and the subsequent operations, including stapedectomy, without general anesthesia. That in chronic middle-ear disease changes seriously impairing the transmission of sound may occur in one part or another of the ossicular chain. The articulations, the fenestral attachment of the stapes, the membrane of the round window, and escape detection except upon subsection to such direct inspection and tests of hearing power and of the patient's sub-

*Read at the May Meeting of the Kentucky State Medical Association. For discussion see p. 29.

jective symptoms as an operation upon the middle ear under conditions of consciousness and freedom from pain would afford. In describing the operation for the removal of the stapes, Dr. Blake says: "From three to five minutes before the operation, a few drops of a ten-per-cent solution of cocaine are forced into the eustachian tube through the catheter; the patient is seated erect in a high-backed chair, his head being held firmly by an assistant. With the patient's head erect it is much more easy for the operator to determine the relative position of the parts of the middle ear exposed by the operation and the angle of attachment of the stapes, a very variable one and of importance from an operative point of view, and that the position of the head can be adjusted at command as the operation proceeds. The incision of the membrana tympani should be made with the paracentesis needle; the cut which I prefer to the one which I have heretofore used for the mobilization of the stapes, and is a modification of that of Miot, but is an incision merely and not an excision of the membrane, and begins at a point midway between the short process and the tip of the long process of the malleus, and close to the manubrium, then extends upward along the posterior ligament of the short process, and follows the periphery to a point posteriorly on a line with the tip of the manubrium. The result being the formation of a flap which falls downward and outward, leaving an unencumbered opening with free access to the subsequent field of operation; bleeding is stilled by a sterilized solution of cocaine; the hearing is tested if desirable, and the operation continued. The next step being the division of the tendon of the stapedius by means of a paracentesis needle, or if the stapes is situated forward and in full view, the division of the incudo-stapedial articulation, which is done with a small triangular knife, a large angular knife being subsequently passed behind the incus to insure separation. An examination of the stapes by means of probe and blunt hook and a repetition of the hearing test help to determine at this stage of the proceedings whether the stapes shall be mobilized or extracted. In the latter instance the stapes should be first mobilized and then extracted. The best instrument for this purpose is a slender, blunt hook, curved very slightly backward, which is passed behind the head and between the crura from below upward. The resistance offered to the traction hook varies considerably. When the stapes comes away entire, there is a sense of contact resistance followed by a sense of suction. When the crura breaks leaving the foot plate in position, the contact resistance

alone is felt. At the moment of removal of the stapes, there is a decided change in the character and rate of pulse; vertigo is not necessarily present, but should always be regarded as a contingency. After the operation the ear should be tightly stopped with sterilized cotton, and the patient kept quiet two or more days.

Operative Measures for the Relief of Chronic Suppurative and Non-suppurative Inflammation of the Tympanum, and the Indication for the Employment of such Measures and the Results Obtained. (E. B. Dench, New York Eye and Ear Infirmary Reports, Vol. 1, Part 1.) Dr. Dench emphasizes the importance of differentiating between nerve lesions and lesions within the middle ear before an operation is advised. On this point he says: "An ear may have been the seat of a suppurative process, as a result of which the membrana tympani may have been almost completely destroyed, and the ossicles bound together. Impaired hearing and tinnitus in such cases might depend upon this condition, or it might depend on nerve lesion. A careful determination of the lesion should be made in every case. A series of tuning-forks of different pitch furnishes the means. In determining the advisability of operative interference for the improvement of hearing, application is made of the well-known fact, that in lesions of the conducting mechanism the normal relation between air and bone conduction is reversed."

In describing his method of operating Dr. Dench says: "A general anesthetic is always necessary for the performance of any intra-tympanic operation. Except in division of adhesions where the membrana tympani has been previously destroyed, the ear should be douched with bichloride 1 to 5,000. I always operate with the head and shoulders elevated, supported on a rest which admits of motion in all directions. Straps prevent the patient from sliding down. When the membrana is intact an incision is made on the posterior superior quadrant, beginning just below the membrana flaccidi, following the course of the insertion of the membrane and of sufficient extent to bring the incudo-stapedial articulation into view. If a single incision does not accomplish this, a horizontal incision may be made from the upper extremity of the first, allowing a triangular flap of drum membrane to be turned down. By cautious manipulation with a fine probe the head of the stapes may usually be brought into view. The tendon of the stapedius should not be divided in the first incision, then the incudo-stapedial articulation will be more plainly seen. Disarticulation is now effected by a triangular knife being passed in front of the long process of the

incus, with the point directed backward and pressed downward through the articulation. With the fine probe the mobility of the stapes is now determined. A horizontal incision is next made at the lowest point of attachment of the membrana tympani, with a blunt knife the membrane is divided close to the tympanic ring from below upward anteriorly and then posteriorly to just above the short process. That portion of the membrana flaccidi above the short process is next divided by the knife being plunged upward and inward above the short process, dividing the ligaments which hold the malleus and the remains of the membrana tympani. Usually the short process of the malleus can be distinctly seen, and it only remains to grasp it with forceps and pressing first inward and then downward and finally by traction outward, this bone with the attached membrani is removed. The next step is the removal of the incus. The ossicle can usually be brought into view by the incus hook. These hooks are curved in opposite directions for the right and left ears. The long process of the incus is seized and by gentle traction downward and outward easily removed; the stapes, if rigid, should be rendered movable by incisions and pressure. If advisable, the ossicle may be extracted by means of a blunt hook passed between the crura.

After the operation a strip of antiseptic gauze is carried to the bottom of the cavity and the canal tightly packed. This method of operating must be modified where the destruction of the membrana tympani has already taken place. The increased vascularity renders the hemorrhage more profuse, thus hiding the deeper structures from view early in the operation. It is advisable to free the stapes early from the surrounding structures before the vascular parts are divided. My own cases at the hospital include twenty-four of chronic suppurative otitis media. In fourteen the discharge was stopped, in eight much reduced, with two recent cases still under treatment. In fourteen the hearing was improved, in nine it remains the same, in one it was apparently reduced. Nine operations have been performed on seven patients in which the membrana tympani was intact. The hearing was greatly improved in four, slightly improved in four, unimproved in one. From what has been shown in the preceding pages, it seems to me that there can be no question that surgical procedures upon the middle ear enable us to benefit a large number of patients who would otherwise be unrelieved.

"Remarkable Improvement in Hearing by Removal of the Stapes."
(F. T. Jack, Trans-American Otological Society, 1892.) Dr. Jack ad-

vocates removal of the stapes without the malleus, incus, and drum membrane in cases of deafness from non-suppurative catarrh of the middle ear. He says not only is the simple removal of the stapes much better in its results, but on the grounds of conservative surgery much to be preferred. It produces the greatest improvement in hearing, with no inflammatory reaction or bad results. The operation is as follows: "The first step is to make a cut shaped like an inverted "V" just over the incudo-stapedial joint, allow the flap to fall forward. This gives a clear view of the articulation. Next separate the stapedius muscle from the head of the stapes; this is done by passing a very slender knife behind the head of the bone. This muscle must be completely severed, otherwise when the stapes is loosened the muscle will pull its head out of sight and cause much trouble in its subsequent removal. Having cut the muscle, the articulation with long process of the incus is then severed by passing through the joint from behind forward a small triangular knife. If not perfectly loose it can be made so by passing a small pointed knife around the head; a small loop now introduced behind the head will with gentle traction remove the stapes. It has seldom been necessary to use cocaine to prevent bleeding. The patients usually remain quiet in bed for two or three days with the ear plugged with cotton.

After reporting in detail sixteen cases, Dr. Jack says, while recognizing the possibility of error in all human calculations, the results obtained in the cases reported are of such a nature as to lead me to be very hopeful of the future of the operation. In general the cases show little tendency to inflammatory reaction. The effect of the operation on the hearing as tested by the watch was not marked either way; in some cases a slight gain, in others a slight loss. The test with König's rod met with similar results. The one result of this operation, which gives it importance and has led me to make this report, is the very marked improvement in hearing the human voice. If persons who have heretofore heard only with difficulty can be made now to hear with ease by treatment unattended with danger, the operation is certainly worth considering. As to the reason this effect is accomplished by the operation, I have no theory to offer other than the simple supposition that it is by the removal of mechanical obstruction to the sound waves.

The Operation for the Excision of the Ossicula in Chronic Aural Catarrh, with Instance of Failure. (Dr. H. V. Wurdemann, in the *Journal of*

the American Medical Association, October 22, 1892.) Dr. Wurdemann said: "Before taking up the subject-matter of my paper I would like it to be distinctly understood that I intend casting no aspersions upon aural operative procedures. I have had marked success both previous to and since the one disastrous result which forms the nucleus of this paper. I can discover but little mention of accidents occurring during or after the operation, and these have all been in suppurative cases. I can find in only three instances the admission of but two operators of unfavorable reports upon hearing. I have excised the ossicles in eleven cases, four of these have been for non-suppurative inflammation. In only one instance has suppuration followed. One year ago a strong, healthy man, aged sixty, consulted me about his ears. He complained of deafness, noises in the head, and vertigo, for which he sought relief. I treated the middle ear of both sides with catheter, using camphor-iodin and camphor-menthol vapor for three weeks with absolutely no improvement of hearing on either side. Despairing of improvement by other means, I suggested an operation. I removed the membrana tympani under ether anesthesia. The operation was clean; although several attempts were made to reach the incus, it was not obtained. There was excessive vomiting after recovery; he complained greatly of vertigo. On testing his hearing on the evening of the second day I was surprised to find he was totally deaf on the operated side. No reaction followed until five days later; he had pain at night, and on the next morning an acute otitis media set up, which ran its course in two weeks." Dr. Wurdemann thinks the lesion was due to a hemorrhage into the labyrinth during the ether anesthesia, or during the excessive vomiting thereafter with subsequent organization of the clot.

A Case of Operation for Catarrhal Deafness. (B. A. Randall, American Otological Society, 1892.) Dr. Randall reported a case of excision of the drum membrane and malleus for catarrhal deafness, followed by suppuration, mastoid empyema, and burrowing abscess of the neck. There was oculo-motor paresis, diplopia, and some mental aberration, suggestive of inter-cranial abscess. A good recovery was ultimately made, but at no time was there any improvement in the hearing. Dr. Randall thinks probably the trouble was caused by the incus being displaced upward, clogging the exit of the antrum and inducing the empyema. The consensus of opinion of a number of competent conservative operators who have contributed the results of their labors in this field during the past year, is that in the chronic suppuration and non-suppara-

tive diseases of the middle ear, uncomplicated by lesions of the auditory nerve, this procedure is not only justifiable but advisable. In suppurative cases the discharge is always diminished and generally entirely cured. The hearing is in the majority of cases markedly improved, especially for the voice. The results on the tinnitus are more variable; in some it is entirely relieved, in others apparently unchanged. There is but slight tendency to inflammatory reaction, with but little danger of further impairment of the hearing.

Altogether it seems that intra-tympanic surgery offers, with a considerable degree of certainty, a reasonable amount of relief to a very large and an exceedingly unfortunate class of cases who have heretofore been considered out of the pale of medical assistance.

LOUISVILLE.

CASES IN ABDOMINAL SURGERY, WITH REMARKS.*

BY DAVID BARROW, M. D.

CASE 1. L. M., aged twenty-four, single, was first seen in October. Her health had been poor for eighteen months; she looked sick, was quite thin, with an anxious facial expression, and had had frequent attacks of intense suffering, attended usually with slight fever. Examination revealed a fluctuating tumor in the abdomen. On November 5th I operated at the Protestant Infirmary, assisted by Drs. Kinnard and Moore. The tumor was multilocular and generally adherent, some of the adhesions being very firm. A cyst was ruptured, and much of the contents escaped into the peritoneal cavity. The other ovary seemed healthy and was not removed, as the patient had requested that one ovary be saved if possible. Irrigation was copious and drainage employed. Duration of the operation forty minutes.

The drainage-tube was removed on the third day. Convalescence was uneventful, and the patient is now well and has since married.

CASE 2. P. H. S., aged twenty, was seen with Drs. Aultz and Heath, of Richmond, Ky., in May. About eight months before she had married, and two months after marriage had been taken sick, being confined to bed most of the time during the six months previous to my visit. Her suffering had been severe and her condition was extreme.

*Read at the May Meeting of the Kentucky State Medical Society, 1893. For discussion see p. 32.

There was a large abdominal tumor, irregular and nodular, part of it seemingly solid, and over the rest there was indistinct fluctuation. Examination *per vaginam* being painful an anesthetic was given. The tumor extended deep into the pelvis, and it was difficult to insert the finger into the vagina or rectum; the rectum was pushed down and the sphincter dilated, presenting the same appearance as when the fetal head is distending the perineum. Through the vagina the irregular, and at some points fluctuating, tumor could be felt. After a most careful and thorough examination we felt uncertain as to the nature of the tumor, but thought it probably an extra-ligamentary ovarian tumor, and advised operation. She was taken to the Protestant Infirmary at Lexington a few days later, and on June 2d I operated, assisted by Drs. Kinnard and Moore.

On opening the abdomen I encountered dense adhesions, and a good deal of force had to be used in separating them; the tumor was almost solid and contained throughout many small cysts, with viscid, mucoid contents, also several pieces of bone, long strands of hair, and sebaceous material. The tumor was traced to a pedicle on the right, and tied off, weighing about twelve pounds. Her condition becoming alarming, and it being evident that she was about to die on the table, I irrigated with very hot water, inserted a drainage-tube and closed the abdomen, leaving the pelvis filled by a tumor. The patient was put to bed profoundly shocked, but under proper treatment reacted slowly. She was out of bed in four weeks and seemed better than she had been before the operation. At the end of the second month her condition had improved a good deal, so I concluded to remove the tumor that had been left.

On August 2d I reopened the abdomen; the tumor completely filled the pelvis, and it was impossible to differentiate any of the pelvic structures. Beginning posteriorly I separated the adhesions, and after hard work succeeded in freeing the tumor from the large and small bowel, uterus, and bladder; it was very much like the first one removed, almost solid, but contained neither bone nor hair. The tissues were very much lacerated and the serous coat of the small intestine was stripped off in several places. The abdomen was irrigated, a drainage-tube inserted, and the incision closed. The tumor weighed about five pounds. When put to bed she was greatly shocked, but reacted fairly well. She seemed to do well for several days, but on the seventh day died from gangrene of the bowel, due no doubt to the injury done in removing the tumor.

CASE 3. K. B., Negro woman, aged twenty-three, married, was first seen in consultation with Dr. M. B. Robinson. She was greatly emaciated and had a haggard and distressed appearance. Ten months before she had discovered a tumor in the lower part of the abdomen, but supposed she was pregnant, although at times her suffering was great. The growth of the tumor had been slow, but when I examined her it extended above the umbilicus. At no time had she been confined to bed. Early in January she went to the Protestant Infirmary, and although the temperature was frequently taken it was never found above 99°. On January 17th, assisted by Drs. Kinnard and Moore, I operated. The tumor was adherent to the abdominal wall, the intestines, and bladder; the sac was friable and ruptured during enucleation, flooding the peritoneal cavity with horribly offensive pus. Several gallons of water were used in irrigation; a glass tube was inserted, and the abdomen closed. Duration of operation thirty-five minutes. The patient when put on the table had a very rapid, weak pulse, and her condition in every way was most unfavorable. At the end of the operation she was profoundly shocked and the radial pulse could not be felt. For a week her condition was desperate, and during that time hypodermics of digitalis and strychnine were regularly given, and occasionally a hypodermic of morphine. After a week the improvement was slow, but progressive, and at this time she is fat and well.

CASE 4. J. W., aged thirty-four, married, was seen with Dr. Coleman in October. She had a large uterine tumor that was causing great suffering, and came to me to have it removed. Two years before she consulted me the abdomen had been opened and the tubes and ovaries removed, but the tumor continued to grow and she frequently bled profusely. The pressure symptoms were marked, and she often had paroxysms of intense pain. On November 14th, at the Protestant Infirmary, assisted by Drs. Kinnard, Moore, and Scott, I did an abdominal hysterectomy. The adhesions from the previous operation were exceedingly firm, and some of them had to be divided with scissors; the tumor was amputated above the vaginal attachment, and the pedicle was treated extra-peritoneally. The duration of the operation was forty-five minutes, and the patient was put to bed in excellent condition. The pedicle came away on the fifteenth day. Convalescence was smooth and uneventful, and the patient returned home at the end of the fourth week. The tumor weighed twenty pounds.

CASE 5. D. J. C., male, aged fifty, was seen with Dr. Molloy on Jan-

uary 1st. He had been sick one day and was suffering very much when I saw him. We diagnosed intestinal obstruction and resorted to the usual treatment. Failing to relieve him, I operated at his home on the night of the 2d, assisted by Drs. Molloy and Kinnard. The obstruction was due to a fecal concretion, completely occluding the ileum. The bowel was incised, the obstruction removed, and the incision closed by the Czerny-Lembert suture. The abdomen was closed and the patient put to bed in excellent condition. Duration of the operation thirty minutes. There was no vomiting after the operation, and the bowels moved the next day. Convalescence was rapid and uneventful, and the patient is now well and attending to business.

CASE 6. B. D., aged twenty-eight, single, was seen with Dr. Rhodes. For several years she had been an invalid, and during the past six months had been confined to bed. Five years before a submucous uterine fibroid had been removed. She stated that she had suffered a great deal at the time of the operation and had been slow in regaining her health. She was hysterical and very despondent. On digital examination the ovaries were felt enlarged and fixed; the uterus was retroverted, and during manipulation her suffering seemed intense. She was taken to the Protestant Infirmary, and on May 15th I opened the abdomen, assisted by Drs. Kinnard, Moore, and Rhodes. The ovaries were found enlarged and indurated, but the adhesions were slight. The tubes and ovaries were removed and the abdomen closed. The patient did well and left the infirmary at the end of the month. Her condition has improved very much, but some of her nervous symptoms continue, and at times she is despondent.

CASE 7. S. S., aged twenty-five, married, consulted me in October. She was extremely nervous and her general health was much impaired. Two years before she had given birth to a child and had been in bad health ever since, and for several months had been confined to bed. A badly lacerated cervix was the only abnormal condition that I found, so I was inclined to think it had much to do with the shattered nervous system. She went to the Protestant Infirmary, the cervix was repaired, she was put on milk diet and kept in bed for six weeks, but without benefit. Symptoms of intestinal obstruction developed and there was much tenderness and pain in the abdomen. Several times I had much difficulty in moving the bowels, it being necessary to use repeated high injections of salts and glycerine. The obstructive symptoms continuing, I decided to do an exploratory operation, so on December 12th I

operated, assisted by Drs. Kinnard and Moore. The viscera were examined, but nothing could I find to account for the obstructive symptoms. At the splenic flexure of the colon there were some slight adhesions; these were broken up, but I did not think them the cause of the trouble. After the operation she seemed better for a while, and returned to her home in Versailles in about six weeks. A letter from the patient received recently states that she is still confined to bed, suffers a great deal, and is extremely nervous, but has fattened and looks as well as she ever did. The operations have done her no good, and I now feel sure that the nervous system alone is at fault, and I believe responsible for her condition, and that the abdomen should not have been opened.

CASE 8. A. R. G., aged thirty-two, was referred to me by Dr. Taylor, of Richmond, Ky. She had two children, one fourteen and the other twelve years old. She had never been pregnant since the birth of the last child, and dates her bad health from that time. She referred the pain to the lower part of the abdomen, was quite nervous, and had to stay in bed much of the time, had not menstruated for six months, and for several years the flow had been scanty and of only a day's duration. Examination revealed the uterus fixed, the adhesions seeming greater on the left than on the right side. On February 14th I operated at the Protestant Infirmary, assisted by Drs. Kinnard and Moore. Both tubes and ovaries were embedded in adhesions, and it took some time to remove them. On the left the ovary was not larger than a pea, on the right not more than half its normal size, and the tube was distended with clear fluid. Duration of operation, one hour, and the patient's condition was excellent when put to bed. The drainage-tube was removed on the second day. Convalescence was smooth, and the patient went home at the end of the third week. In a letter recently received she says: "I am still improving and doing as well as I possibly can; do not suffer any pain, and my appetite is good. I do hope that my health will be better than ever before, and I feel that it will."

CASE 9. A. B., aged thirty-four, married twelve years, was referred to me by Dr. S. L. Helm, of Spears, Ky. She had been a sufferer since the birth of her only child, now ten years old. On examination the cervix was found lacerated, and to the left of the uterus there was an exudate. The patient was quite nervous and seemed to suffer greatly during the examination. She had had local treatment frequently, but had not been benefited. Menstruation was regular, but never lasted more than one day, and frequently there was barely a show. Dr. Helm

had told her that an operation was necessary, and she was anxious that something radical be done. On March 28th I operated, assisted by Drs. Kinnard, Moore, and Helm, at the Protestant Infirmary. On the left there were a good many adhesions, and it took quite a while to remove the tube and ovary; on the right the adhesions were slight, but I thought it best to remove that tube and ovary also. The ovaries were quite small, not more than one third their normal size. The convalescence was smooth, and she returned to her home in one month, free from pain and apparently well.

CASE 10. L. C., aged twenty-three, married four months, was seen at the Protestant Infirmary with Dr. J. C. Carrick, on March 16th. She was from Ashland, Ky., and had come to Lexington for treatment. On November 12th she had married, and on the 13th menstruated, the period lasting four days. December 13th she again menstruated. On December 23d she fell on the pavement and was caught under a gate and the abdomen very much wrenched. Since the fall she has suffered, being in bed a good part of the time. On January 13th she menstruated, the period lasting only two days, and some clots were passed. The next period was February 23d, the flow lasting from that time until about March 7th, some clots of blood and what seemed to be little particles of membrane were passed. For a week she had had daily paroxysms of pain in the lower part of the abdomen, so severe as to require morphine. There was no nausea or other sign of pregnancy. On examination the uterus was found a little enlarged, looking forward and slightly fixed; to the left was a mass firmly fixed and about the size of a walnut. On the right there seemed to be some unnatural fullness, but nothing definite could be made out. During the examination there was a quantity of bloody discharge from the uterus, containing decidua. I thought it probable that the case was one of ectopic gestation. On the 18th I made another examination, and, believing more firmly that my diagnosis was correct, advised operation. On the 21st I opened the abdomen, assisted by Drs. Kinnard, Moore, and Carrick. On the left was quite a mass firmly adherent to the sigmoid and omentum. In enucleating the sac, about the size of a walnut, it ruptured, and its contents escaped. After much difficulty I succeeded in removing the sac, which was the left tube; the omentum being torn in freeing it from the mass was ligatured and cut off. On the right an ovarian cyst, about the size of an orange, was found and removed. The cavity was irrigated and a glass drainage-tube inserted. Duration of operation one

hour. The patient took ether badly and came near dying on the table. She was put to bed with a pulse of 120, and considerably shocked, but reacted fairly well. In emptying the drainage-tube, ten hours after the operation, the fetus was caught in the nozzle of the syringe and removed. It was not more than two thirds of an inch long, but could be positively made out as being a fetus, and was, I judge, in the sixth week of development. Convalescence was uninterrupted and the patient is now well.

CASE 11. R. M., aged forty-four, married, was first seen by Dr. Skillman on February 12th. In December she had been taken sick with violent abdominal pains, nausea and vomiting, with obstinate constipation. During January she had two similar attacks, and in one of them it was nearly a week before the bowels could be opened. Her menstruation had always been regular, but very scanty for two years, and in January there had been no flow. The patient had lost a good deal of flesh but was still well nourished, and at my visit was more comfortable than she had been for a month. She had been married twice, living with the first husband for a good many years, and with the last one seven years, but had never been pregnant. Examination revealed a fibroid uterus, about the size of a cocanut, filling the pelvis and extending into the left iliac region; the uterine cavity measured three and one half inches, and no bleeding followed the introduction of the sound.

On March 11th I again visited the patient. There had been no severe suffering since my last visit, one month before, but a good deal of abdominal pain and soreness, and it had been almost impossible to keep the bowels open, notwithstanding purgatives and enemata were continuously used. The tumor had grown rapidly and extended up to the umbilicus. Pregnancy in a fibroid uterus was suspected, and the husband so informed, but I inclined to the opinion that the rapidly growing tumor was a sarcoma. On March 25th I was called to the patient and found her with peritonitis and suffering intensely; the abdomen was greatly distended, the tumor had continued to grow rapidly, and was extremely sensitive to manipulation; there was nausea and vomiting, and the bowels were obstinately constipated. I was forced to give hypodermics, so intense were her sufferings. Purgatives and enemata were employed, but it was several days before the bowels moved, and then not satisfactorily. From March 25th to April 11th the patient remained in bed, scarcely able to change her position on account of pain, unable to take but little nourishment, and daily losing ground, with total intestinal obstruction threatened.

On April 11th she went to the Protestant Infirmary. It was evident that an operation was necessary; without it she could live but a short time, and there was nothing but suffering to look forward to. The family were fully informed as to her condition. It was my opinion that the tumor was probably a sarcoma, but pregnancy in a fibroid uterus was a possibility, and this was stated to the family and the physicians present. No matter whether pregnancy existed or not, it was necessary that an operation be done, and this opinion was given and the operation advised. On April 13th I operated, assisted by Drs. Scott, Moore, and Carrick. The tumor extended almost to the diaphragm, was extremely muscular and intimately adherent to the intestines and omentum, and was firmly fixed posteriorly. Every thing seemed a large fibroid mass, and on the surface coursed blood-vessels as large as the little finger; the peritoneum was of a dark livid color, and an active peritonitis was in progress; the intestines were full of gas, coils of small intestines were firmly and closely attached to the tumor, and why total obstruction did not exist I can not understand. The adhesions were separated with great difficulty and a great many ligatures were necessary to control hemorrhage; the lower part of the tumor, as large as my thigh, was encircled by an elastic tourniquet. On cutting into the masses several abscesses were opened and a quantity of pus escaped into the peritoneal cavity. On entering the uterine cavity a fetus was felt, which with the placenta was quickly delivered through the incision. Pregnancy had advanced to about the four and a half months. The *serre-neud* was placed about the pedicle and the elastic tourniquet removed; the mass above the *neud*, the fibroid, and most of the uterus, was cut away, and the pedicle was transfixed and fixed into the lower end of the incision. The small bowel was injured during the manipulation, but was immediately stitched. The peritoneal cavity was copiously irrigated and a glass drainage-tube inserted. Duration of the operation one hour. The pulse was less than 100 when the patient was taken from the operating-room, and her condition was satisfactory. With the exception of nausea and vomiting she seemed to do well for three days, when septic peritonitis developed. After the third day she slowly grew worse, and, on the seventh day after the operation, died of septic peritonitis. The bowels never moved after the operation, notwithstanding purgatives and enemata were repeatedly employed. The pulse remained good until the last; the temperature was practically normal throughout, and there was never great abdominal distension.

Remarks. The cases reported in this paper have been selected from a number of operative cases because of their unusual interest. Most of the operations were difficult, much more so than in the majority of operations done by abdominal surgeons. My earnest wish has been to be candid in my report, and state simply facts, and I hope that in this I have succeeded, for, if I have not, this report can be of but little use to myself or any one else. In all of the cases except one, the necessity of surgical interference could not be questioned, but in that one (Case 7) I am candid to admit I was misled by symptoms and did an unnecessary operation, subjecting the patient to some risk without in any way benefiting her. It is difficult to decide in many cases of pelvic inflammation the best treatment to adopt, and it is often necessary to keep such cases under careful observation for a time before giving positive advice. Most of us have been disappointed and sorely tried by some case not benefited by cœliotomy. The operator had removed the tubes and ovaries, the patient had returned to her home believing that soon she would be well, for the surgeon had removed, as he thought, the cause of her suffering. In a few months she realizes that she has not been benefited; the family physician is again called, and worries along with the patient indefinitely. On the other hand, when cases are properly selected for operation there will be but few disappointments, for there is no surgical procedure giving such brilliant results as do properly done cœliotomies in cases judiciously selected. To have patients almost dead with intra-peritoneal disease restored to health and happiness in a few weeks is indeed a pleasant reflection. The operative skill and technique employed in this special work has well near reached perfection, and is as near ideal surgery as we can expect to attain, and in properly selected cases no one can criticise the results.

The importance of carefully studying a case before resorting to operation can not be too earnestly insisted upon, for an occasional too hasty resort to operation in non-suitable cases has been the cause of severe criticism on the part of some members of our profession. I admit there is some slight ground for this criticism, for I have known the abdomen to be opened when I thought the operation should not have been done, but this is certainly very exceptional. To study and watch the "border line" cases before giving positive advice will repay the surgeon, and will hush the carping of those who are inclined to criticise unjustly and magnify and multiply an occasional error.

**SPLENECTOMY FOR SCIRRHOUS CARCINOMA;
DEATH FROM SHOCK.***

BY HARRY J. COWAN, M. D.

On February 17, 1893, I saw, with Dr. H. Brown, of Hustonville, Mrs. L., white, aged ——, the mother of six children; menstrual life regular. There was no history of important sickness prior to about February, 1892, when she began to have severe pain in the left hypochondriac region. This pain would last for several days, sometimes as long as a week, and then recur at intervals of about two weeks. She had been confined to bed for two months, was emaciated, and had an anxious expression. The exertion of sitting up for examination caused free perspiration. The appetite had remained good, except when the patient was taking morphia. Eight months previous to my visit she had observed a small "cake" below the free border of the ribs, on the left side of the abdomen.

A firm, immovable tumor occupied the left hypochondriac and lumbar regions, extending upward beneath the ribs, inward to the right of the median line, and downward into the iliac region. A line of tympanitic resonance could be heard over its anterior surface a slight distance below the free border of the ribs; there was resonance low down in the loin behind. The examination revealed no evidence of other disease.

In the consultation diagnosis of tumor of the kidney or spleen, most probably malignant disease of the spleen, was made, and operation advised.

Operation March 9th, Drs. H. Brown, George Cowan, Moore, Alcorn, and Humphries being present and assisting. Incision in the left semi-lunar line; omentum adherent both to the abdominal wall on the anterior and inner surfaces of the tumor. Obscure fluctuation was felt, and the tumor aspirated without result. As the adhesions were being separated the colon was seen overlapping the growth and bound down to it by adhesions. Upon enucleation the diseased organ proved to be the spleen. The pedicle was isolated with some difficulty, due to omental adhesions in the hilum, grasped with forceps, and, after removal of the tumor, tied with three interlocking ligatures, reinforced behind by a Staffordshire knot; abdomen flushed, drained, and closed.

* Read at the May Meeting of the Kentucky State Medical Society, 1893. For discussion see page 39.

Time of operation, an hour and fifteen minutes. Patient died from shock three hours after.

The spleen was estimated to have weighed twelve or fifteen pounds, and was largely made up of a yellowish, semi-solid material in three distinct foci, between which there was apparently normal splenic tissue. The capsule was nowhere broken, and none of the adjacent organs involved, so that the case was a favorable one for operation.

A part of the specimen, consisting of the smallest focus of disease, together with some surrounding normal tissue, was examined by Dr. Louis Frank, of Louisville, who kindly sent me the following report:

LOUISVILLE, KY., March 28, 1893.

DEAR DOCTOR: The spleen sent me for examination proves to be very much decomposed, but was nevertheless put in alcohol and cut, giving by microscopic examination the following:

Splenic (?) tissue so decomposed as to be not easily analyzed, but showing no apparent deviation from normal, except in the capsule, which is thickened and the seat of the carcinoma. This carcinomatous tissue is at the seat of a large, soft, puffy mass, observed microscopically at the edge of the tissue. The basement tissue of the cancer is dense fibrous tissue, between which the cancer cells are infiltrated.

Diagnosis: Scirrhus carcinoma (of capsule) of spleen, probably metastatic.

Respectfully,

LOUIS FRANK.

Splenectomy for disease is attended with a high mortality, the deaths being from hemorrhage or shock. Prior to Pean's successful case in 1867, which was done for cystic disease, there were on record three authentic cases, the patient in each instance dying from hemorrhage a few hours after operation. Mr. Wright,* of Manchester, has collected sixty cases, twenty-two for leucocythemia, all fatal; twenty-three for simple hypertrophy, with fifteen deaths; seven for malarial disease, with two deaths; and three for cystic disease, all of which recovered. Ashurst† reports forty-three cases, to which he had references; thirty-one of these died.

Leonard‡ gives a table containing all reported cases of splenectomy between 1881 and 1887, seventeen cases, twelve of which recovered and five died. In commenting on this table he says: "It is possible, however, that all the fatal cases have not been reported. Thus Mr. Tait refers to two instances within his knowledge in which hypertrophied spleen was mistaken for ovarian tumor, and the operation for these

*Treves' Operative Surgery.

†Medical News (Philadelphia), August 17, 1887.

‡International Encyclopedia of Surgery.

supposed cysts terminated fatally in both instances, no report of the mistakes ever being published. . . . In the discussion which followed the report of Crede's case before the German Surgical Society, six other cases were mentioned by different operators, with but one recovery."

From Sajous' Annual I have collected eleven cases, reported from 1888 to 1891 inclusive; seven recovered and four died.

Mr. Greig-Smith,* after a review of the literature of the subject, sums up as follows: "Operations for leucocythemiac spleen are unjustifiable. Operations for traumatic lesions are justifiable and safe. . . . For cyst the spleen may be removed with a fair chance of success, but puncture or incision with drainage should have a trial first. In the early stages of malignant disease the operation is justifiable."

DANVILLE, KY.

Reports of Societies.

KENTUCKY STATE MEDICAL SOCIETY.

Thirty-eighth Annual Meeting, Frankfort, Kentucky, May 10, 11, and 12, 1893.

THURSDAY, MAY 11TH—MORNING SESSION, CONTINUED.

Dr. Curran Pope, of Louisville, read the Report on Diseases of the Mind.

The paper gave a good showing of progress in neurology, especially in neuro-therapeutics, for the year past. Hydro-theraphy (Baruch) in degenerative disease of the spinal cord, thyroid gland, by mouth or by injection, in myxedema, stretching the spinal column in tabes (Bun-nuzi), barium chloride (Lisle), and carotid compression (Kelly) in epilepsy, quinine (Dasciani) in hystero-epilepsy, linear craniotomy (Engel) in dementia epileptica of childhood, extract of cerebral gray matter by injection (Paul and Hammond) in neurasthenia, were duly described and commented upon.

Seguin's discussion of the relation between eye strain and cerebral hyperemia, and John Ferguson's studies upon the symptomatic value of knee-jerk were given. The writer called attention to the treatment of artero-sclerosis (Church) by iodide of potassium, and quoted Fergu-

* Abdominal Surgery.

son on the management of the "Insanity of Exhaustion after Acute Diseases." Home treatment is best. Be "kind, firm, persevering in your attention," and never do any thing to make the patient distrust you. Secure sleep. "Equable temperature and forced feeding are necessities." Do not substitute the insanity of drugs for the insanity of disease. Use great care not to initiate your patient into the habit of taking hypnotics. In this connection Baher's warning as to the indiscreet prescribing of sedatives, stimulants, and narcotics in the treatment of nervous diseases with recurring symptoms (exhaustion, insomnia, and pain) was repeated. "He is a skillful physician who can treat insomnia without drugs. Charcot's chair for imitating the motion of railroad cars in the treatment of paralysis agitans, and Gilles de La Tourette's helmet for localizing vibrations to the head in the treatment of insomnia, migraine, neurasthenia, and melancholia were mentioned. The helmet was exhibited to the Fellows.

Advance in electro-therapy (Caldwell and Morton), especially in new uses for the statistical form, and the general recognition of the advantages of the polar method of treatment were noted.

The paper closed with an account of recent advances in hydrotherapy. The teachings of Weir-Mitchell, Peterson, Baruch, Ransom, Charcot, Erb, Winternitz, and Nothnagel relative to the uses of water in therapy were duly commented upon, and the author exhibited certain pieces of apparatus for the application of the measure in practice.

DISCUSSION.

Dr. F. H. Clark, Lexington: I wish to add my testimony to what has been said of the abuse of hypnotics. To get along without them is one of the most difficult things for neurologists and alienists. A large measure of the success of the treatment in asylums and public institutions is due to the fact that in these places the physicians use very much less of hypnotics than is necessary in outside practice.

In regard to vibratory apparatus, I know of it only through the medium of journals and to-day's exhibit, but I want to suggest a partial means to meet the same end in the hands of the general practitioner. I believe that by the galvanic current properly interrupted, or the faradic current properly mitigated, we ought to secure results equal to those obtained by the vibrator. The value of electricity in inducing sleep, and in relieving pain is too well known to call for comment. We may also effect a kind of mechanical massage by general faradization.

Dr. Pope: Dr. Clark's mention of electricity as a substitute in the hands of the general practitioner for the helmet calls for a word. I think the

vibration of the faradic current too strong in treating nervous patients; but if we wish a very strong effect from the electric current, we should use the polar method, in which one of the poles is placed upon a neutral point, and the other applied to the cranium. Very good results may be obtained in this way which can not be had from the same current otherwise administered.

As to the treatment of insomnia by hypnotics, my experience has been that of Dr. Clark. I have found heretofore but three things that are useful in the treatment of insomnia: hydro-therapy, electricity, and massage, in the order named.

Dr. W. L. Rodman, of Louisville, read a paper on the subject of Tumors of the Neck. [See p. 1.]

DISCUSSION.

Dr. H. H. Grant: I am glad to hear Dr. Rodman emphasize the danger of hemorrhage in operations about the neck; and I am also glad that he called our attention so particularly to the dangers of septic infection. It is in this point particularly, in operation for the removal of enlarged glands, that the danger lies, I think. There is even greater danger of the slipping down of the discharges from the infected wound than of fatal hemorrhage during the operation. No man can do an operation in the neck, especially where an incision is not freely made, without a nervous feeling when he undertakes to enucleate any of the glands that are deeply inserted; but it appears from Dr. Rodman's statements that even the division of the internal jugular is not attended with great danger, if, of course, done directly under the eye of the surgeon. Fatal hemorrhage and the entrance of air into the veins are the great immediate dangers in operations here; but if the incision be made freely, not only are these dangers avoided, but the danger of sepsis from the hidden discharges is very greatly lessened. Dr. Rodman refers us to the consideration of lymphadenoma and tubercular adenitis together. In my experience in the early stages of lymphadenoma there is a very marked resemblance between it and tubercular adenitis. These enlarged glands begin, as far as my knowledge goes, upon one side, and not upon both; they gradually spread, however, to the other side. In tubercular adenitis there are usually enlarged glands on both sides, and although the location is a little different it is not by any means a common thing for lymphadenoma to begin on both sides. Usually it spreads gradually around beneath the neck, but the symptoms in the earlier stages are much alike.

It appears from what Dr. Rodman recommends that operative interference is indicated in all tumors of the neck, except those of malignant disease. Therefore diagnosis is not of great importance, provided we can exclude malignant disease, and especially that malignant disease which directly attacks the thyroid body. I am entirely in accord with Dr. Rodman in respect to the propriety of complete thyroidectomy not being justifiable; but a very small portion of the thyroid gland may be left and

perform its function. It is true that this operation is of no value in the treatment of malignant disease. The author did not call our attention to the presence of that form of tumor known as actinomycosis, which is prone to occur on the face. My experience has not led me to observe such tumors in the neck; in fact, I never saw them there, nor do I recollect to have seen a report of a case occurring in this region; but it occurs to me, from its being so common in the face, that it is likely to show at least some of its secondary manifestations in the neck. If tumors of this character should appear in the neck they would have to be discriminated from other tumors in this region. Dr. Rodman has so very many times presented in various societies the subject of tumors that I am disposed to refer to him altogether as an authority.

Dr. Rodman: In one point, as to the diagnosis between lymphadenoma and tubercular gland, I take issue with Dr. Grant. Tubercular glands almost invariably are unilateral in the earlier stages of the disease, beginning in the submaxillary triangle, and being confined to one side. This, though sometimes diverged from, is decidedly the rule; but lymphadenoma appears on both sides simultaneously. Tubercular glands appear at the upper part of the neck, and lymphadenomata in the lower triangle. What the doctor says as to actinomycosis is true. We might have secondary trouble in the neck, but I referred merely to the primary manifestations of the disease.

Dr. T. B. Greenley, of Orel, read the Report on the Mortuary Statistics of Kentucky.

Dr. W. R. Blue, of Louisville, read the Report on Genito-Urinary Surgery.

Dr. E. E. Hume, of Frankfort, read the Report of the Committee on Credentials.

Dr. W. O. Green, of Louisville, read the Report on Rectal Diseases.

Dr. T. C. Evans, of Lexington, read the Report on the Progress of Otology. [See p. 9.]

DISCUSSION.

Dr. S. G. Dabney: I wish to speak, not in regard to the treatment, but in regard to the diagnosis of cases of middle-ear disease that are likely to be benefited by operation. There are two points worthy of attention; one is that patients who have extreme disease of the middle ear are apt to hear better when there is a loud noise; the other is that the tuning fork C, which is the one generally used, is heard better when pressed upon the bone back of the ear than at the meatus externus. Practitioners who are in doubt as to whether cases are fit for operation should observe these two points. If a patient hears better in a quiet place, most likely the nerve of hearing is affected, otherwise the middle ear is affected; bone conduction is better when the middle ear is the seat of disease, and aerial better when the disease involves the labyrinth.

Dr. Henry E. Tuley, of Louisville, read a paper on Stomach Washing in Infants.* At the close of the paper Dr. Tuley exhibited the apparatus used. It consisted of glass tubing, a funnel, and catheter.

DISCUSSION.

Dr. J. C. Cavanaugh: I rise simply to indorse the paper, and ask that the profession give it a trial. I saw some most marvelous results following irrigation of the stomach in 1889. I use it now in practice, and have been perfectly charmed with the result. It is a very simple measure. It may be used by the mother or the nurse with impunity.

Dr. Cecil: I would like to ask the doctor if, in the use of the tube, he ever passed it or has known it to be passed into the larynx.

Dr. Tuley: I have never seen it passed into the larynx. I have seen tyros attempt to introduce the tube, and always without difficulty; the only difficulty experienced was in the stomach tube's curling up in the mouth, but that was because the tube was a little too flexible. Any gentleman who has practiced intubation will readily see how difficult it is to pass an intubation tube into the larynx, and it is almost impossible to get a soft catheter into the larynx. It will readily pass into the esophagus.

Dr. David Barrow, of Lexington, read a paper entitled Some Cases in Abdominal Surgery, with Remarks. [See p. 15.]

Dr. W. C. Dugan, of Louisville, read the Report on Abdominal Surgery (Appendicitis).*

Dr. L. S. McMurtry, of Louisville, read a paper on the Etiology and Pathology of Intra-Pelvic Inflammations in Women, illustrated with specimens and cases.

The essayist passed a number of specimens around before reading his paper, with the following remarks: "The etiology and pathology of pelvic inflammation in women constitute a condition that has for a long time been known to the profession as pelvic cellulitis, and I have had photographs of some specimens made in order to illustrate the pathology of this condition. The two photographs illustrate a case of double pyo-salpinx with cystic ovary. Here is a second specimen of the same kind that has been kept in alcohol for five weeks. When this specimen was removed the fallopian tube and ovary were found bound together by plastic exudate and filled with pus; you can see the place where it ruptured, letting an amount of foul pus into the peritoneal cavity; the specimen has shrunk very materially in the preserving solution. The operation for the relief of such a condition we often hear spoken of as removal of the ovary. We find little evidence of any ovary here. The

*Will be published in a subsequent issue of the American Practitioner and News.

left ovary is included in this mass, and you can see the fallopian tubes and ovary all converted into one large thick sac, which is a pyo-salpinx, the ovary and all amalgamated. Here is a specimen of the same character, and I will allude to these specimens in the course of my paper. Here are smaller specimens of the same thing. Here is a fallopian tube filled with cheesy pus amalgamated to the ovary. On this side we find the same process not involving the ovary; the tube is occluded, but the ovary is healthy. This operation was done in the midst of an active peritonitis, brought about by an operation on the cervix. This illustrates inflammation of the uterine appendages."

At the conclusion of his paper Dr. McMurtry said: "I have selected these few cases that I have reported from a number, as indicating the various features in the etiology of pelvic inflammation as well as illustrations of the lesions that result therefrom.

"The large specimen is from a case which, so far as can be traced, had its origin in a latent puerperal infection. An active peritonitis was kindled by a forcible dilatation of the cervix. I may be a little dogmatic in the assertions that I have made about forcible dilatations of the cervix, but my observations of the results of this operation, seen a long time perhaps after the operation, have led me to the conclusion that although very beneficial results have been attributed to it, yet it is more prolific than any other of the minor gynecological operations in producing disease of the uterine appendages. This case illustrates two points: first, the difficulty in the diagnosis of pelvic inflammation; second, how much can be done in cases of pelvic inflammation by standing up and doing our duty fully in an extremity. This case I saw in consultation with a gentleman from Louisville. The patient was a married lady, thirty-two years of age, and the mother of four children; she had been confined a little over a year before this occurrence, and we saw her first on last New Year's Day. She had been out sleigh-riding the Sunday before, eight days previously, and jumping out of the sleigh began complaining of pelvic pain; she was seized with pain in the abdomen, carried up to her room and put to bed in a condition of semi-collapse. Very active peritonitis succeeded. The entire pelvis became packed, so that the catheter had to be used; an ordinary soft rubber catheter would not go through the urethra, such was the pressure against the pubic bone. Her pulse was 136, temperature 104.5°, vomiting, flushed faced, swollen belly. A conditional diagnosis of ruptured tubal pregnancy was made. That is a condition that is absolutely inca-

pable of differential diagnosis, as a ruptured ectopic pregnancy and a ruptured pyo-salpinx both have a history of chronic peritonitis. In both the patient is seized with collapse; both conditions are succeeded by peritonitis. On the following day the patient was operated upon. Her temperature was taken just before the operation by a careful observer, with a reliable and tested Hick's thermometer. It was sub-normal; pulse thin and small; case very unpromising. On opening the abdomen a large quantity of pus escaped; the left fallopian tube was ruptured, and let it pass into the abdomen; it was found by odor; in stripping the sac open on the other side violent hemorrhage resulted; in attempting to arrest that hemorrhage of the uterus occurred. The uterus was found to be rotten, and the entire body of the uterus came loose from the cervix uteri, so as to establish a terrible hemorrhage, and that was arrested simply by placing a clamp on the cervix uteri. The abdomen was irrigated; the opening was shut off by gauze packing, and a glass drainage-tube was used; abdominal incision left open, gauze and clamp sticking out; patient had no pulse whatever, wrist or temporal; patient put to bed; a reaction set in, and after six days the wound healed up entirely, the clamp was removed at the end of forty-eight hours, and no hemorrhage took place; there was perfect recovery.

"I report this case out of a number of cases of pelvic inflammation simply to establish that even in great extremity it is proper to operate. We should operate, and when we get into the operation do our duty thoroughly. One single life rescued in this way by an operation justifies the operation in every case. Of course record-makers, who do not want any fatal results, had better let such cases alone; but one such case is sufficient to justify the operation in all similar cases of suppurative inflammation of the pelvis, and I report it to show how difficult is the diagnosis, and how insidious is the approach of the disease."

Dr. J. G. Carpenter, of Stanford, read a paper on the Conservative Surgery of To-day. [See Vol. xv, p. 401.]

The papers of Drs. Barrow, Dugan, McMurtry, and Carpenter were discussed jointly.

DISCUSSION.

Dr. Cecil: I was interested in hearing the reports made by Dr. Barrow, and entertained in the excellent resumé of Dr. Dugan on the subject of Appendicitis. But the point that I wish to address myself to is that relating to a portion of Dr. McMurtry's paper. The author emphasized as the causes

of pelvic troubles inflammations occurring especially in the tubes and about the ovaries. The two causes which I think deserve even more especial emphasis are puerperal sepsis and gonorrhea. In my judgment and in my observation these two causes are largely responsible for the conditions which render the knife imperative. I must take issue, however, with the doctor on his position in regard to some of the minor gynecological operations which I believe yet have a place in gynecology. I believe that some of these minor operations have done more for the relief of suffering and the saving of life than any of the major operations, such as the removal of the tubes, ovaries, ovarian cysts, and other tumors which occur in this region. But there is a field for the dilator, and I was rather surprised that the writer took such emphatic grounds on this subject. No doubt he felt justified in the harm that it has done in unskillful hands, but I can not agree that it is responsible for so many troubles as he seems to attribute to it. There are conditions of the womb which demand treatment, which do not demand surgery, which can not be treated unless there is a free and easy access to the cavity of the womb. In such conditions as follow labor, in such conditions as follow abortions particularly, in such conditions as we find in chronic womb diseases, which are generally going to terminate in endometritis, endocervicitis, etc., and particularly of the chronic gonorrheal kind, I maintain it is good practice to dilate the cervix, and I do not believe there is any safer operation, if properly done, than to dilate with a steel dilator. Do it quickly, under the strictest aseptic precautions. I do not think it is a dangerous operation, but it ought not to be performed in a haphazard way, as it often has been done; it ought to be invested with all the dignity of an operation, and where it is so dignified it will not be followed by the dire results that have been indicated in the paper. If we were to abolish the use of the dilator, I believe that we would be handicapped in the treatment of many of the diseases which do not and ought not to come into the hands of the pelvic surgeon. I therefore can not concur with the author that the dilator is such a source of trouble. I believe that the medical profession in general is being educated up to a point very rapidly where it is made known or apparent that all operations about the uterine cavity should be invested with all precautions; and when this is done we shall not see such results as the author depicts. I have seen this operation followed by many good results; I have seen so many cases that have defied medical treatment resulting in cure, in thorough cure, that I can not, for one at least, agree to abandon the use of these instruments. I agree with him that they have been abused, most sadly abused, and I agree with him also that many cases of pelvic trouble demanding the knife are strictly attributable to dilations and to curettings, and to other operations of that class; but when they are done properly, when they are surrounded with all the precautions necessary, I do not believe that they are potent for harm.

Dr. F. J. Yager, Campbellsburg: I rise to approve the gentleman that made the discrimination and the investigation in relation to the general

instruments that we use for exploratory purposes. I do not see the injury that can result in the use of dilators. I was not competent to doubt one word that Dr. McMurtry said, and since Dr. Cecil has brought up these things he has given me an item of thought that I may have some appreciation of the investigation of these subjects, and I want to say that I feel proud that these young men have made these investigations, proud of the progress of medical science and surgery, and I feel now an inch taller than when I got here yesterday to see the great advances that we have made in the general operations of medical and surgical science.

Dr. William H. Wathen, Louisville: For the second time I am pleased to commend the position taken by Dr. Barrow in his report, especially to commend his honesty in presenting facts observed in his own experience just as he has seen them. The only way we can arrive at many conclusions accurately is by honest and accurate reports of the results of observations and of work, the good results and the bad results alike, and Dr. Barrow seems to be capable of accomplishing these two ends. He acknowledges that he has possibly operated upon one case that should not have been operated upon. I think I have done the same thing more than once. But by report of experiences of this sort, as we grow older in experience and observation, if we are honest in observation and honest in work, we do better, and the mistakes of our early work are not so often repeated. In the report of the case of hysterectomy, with a fetus in the womb, I am inclined to the opinion that had he introduced a large gauze drain in addition to the tube this woman would have been given a better chance for life. I was educated to believe in the tube to the exclusion of every thing else in abdominal drainage, and to drain in nearly every case. I have written one or more papers taking this position; but I have somewhat changed my opinion, and I am now not such an earnest advocate of drainage as I formerly was; and I believe if surgical work is done cleanly that drainage is not very often necessary, and that the patients will recover about as readily without it as with it, and that by avoiding drainage we likewise avoid certain elements of danger that necessarily exist with it. But there are cases that, with our present knowledge of abdominal surgery, with all the technique that we now know any thing about, must be drained, and it is a question which is the most efficient manner of drainage. If drainage is efficient, its efficiency consists in the removal in the most complete manner of secretions of whatever character within the abdomen and pelvic cavity. Of course, if these are removed, we take away the pabulum upon which the pathogenic germs may develop and multiply into fatal peritonitis. Now, then, if that be true, there is no method of drainage that accomplishes this in a manner comparable to gauze.

Dr. J. G. Carpenter, Stanford: In regard to exploratory incisions, we should make the diagnosis sufficient to know that there is a pathological lesion endangering health or life, and in that way an exploratory incision is demanded; but just to make an exploratory incision to see if there is

something in the abdomen is all wrong. We should operate for pathological lesions and remove them when we find them, if they can be removed. I have seen time and again specimens of diseased tubes and ovaries produced by dilatation, curetting, caustics, and uterine sounds. It is said that fibroids are harmless, and that the menopause arrests their growth. In the majority of cases the menopause does not arrest their growth. They are dangerous to remain; they cause death by hemorrhage, pressure, and exhaustion, and they undergo gangrene. Of all growths they are the most frequent to undergo cancerous degeneration. I have seen a number of fibroids, and the advice has been given to leave them alone until after the menopause; but they underwent cancerous degeneration. The abdominal surgeons of Philadelphia confirm me in this point, that fibroids are the most prone of all tumors to undergo cancerous degeneration after the menopause.

As to whether drainage has been abused, I would say that each case of abdominal section is a law unto itself as to drainage, and a number of them do not need irrigation or the drainage-tube. The peritoneal cavity has not been infected, and in that case there is no need for drainage. There are others which present numerous adhesions with danger of hemorrhage, and in which the peritoneum has been infected by rupture of the dermoid, or in which there has been cancerous degeneration going on of a part of the tumor, and in these it is imperative to irrigate and drain.

Dr. H. H. Grant, of Louisville, read a paper on *The Management of the Damaged Gut in Strangulated Hernia*.

Dr. J. M. Mathews read a paper on *Diseases of the Rectum*.

The President announced the officers for the ensuing year, as follows: President, Dr. J. Q. A. Stewart, of Frankfort; Vice-President, Dr. O. D. Todd, of Eminence; Second Vice-President, Dr. C. D. Mansfield; Treasurer, Dr. J. B. Kinnaird, of Lancaster; Librarian, Dr. Frank Boyd. Board of Censors: Dr. B. F. Eager, Dr. B. F. Harrington, and Dr. O. F. Cash.

The next place of meeting was fixed at Middlesborough, Ky.

The committee recommends that the Committee of Arrangements be requested to arrange for surgical, pharmaceutical, and other displays for future meetings of the Society in a building entirely separate from the building in which the meetings of the Society are held.

The report was adopted.

Dr. August Schackner, of Louisville, then spoke as follows on the *Care and Construction of a Modernized Outfit*:

The time allotted me is so short that in place of reading a paper on this subject I thought I would consume the whole time in exhibiting and going

over the features characteristic of the case. There are a few features here that are somewhat original and advantageous, to which I will call your attention. What I have here is a complete general operating case. It contains all the instruments necessary for any operation excepting necrotomy. The instruments are also so arranged and placed as to be kept in a perfect aseptic condition without any trouble whatever. I carry on the outside in this roll operating overalls. In addition to that there is also sufficient room here for slipping underneath a rubber sheet to place upon the table to make it impervious. The overalls are made of ten-ounce ducking, and are of one piece, entirely closing behind. This constitutes the suit. It completely covers the operator; it can be sterilized after each operation by boiling; it has arms to the elbows. At first the ducking seems entirely too heavy, but I would always advise you to get ten-ounce ducking, because each washing makes it softer, until finally it is about as pliable and soft as cotton would be.

One feature of the case is that every possible space has been employed. Upon half of the lid we have five bottles. In this I carry tincture of digitalis, an ethereal solution of bichloride of such strength that four drops represent one grain. Upon this bottle I have a formula for rapidly making solutions of bichloride of any strength desired. In the next bottle I carry sal soda to sterilize instruments and to keep them from rusting during boiling. The next bottle contains permanganate of potash, and the next oxalic acid with which to sterilize the hands. Next is a small box containing needles, fifteen strands of silk-worm gut, and enough silver wire for one abdominal suture. In the next box I carry a tourniquet, which is completely isolated, and if it should be applied to an aseptic case it would be on its return into the box entirely isolated from any other part of the case or instruments.

In the next box I carry two sets of safety pins, two dozen each; in the next I have a duster for carrying the dusting-powder; in this case it is boracic acid. In the next bottle I carry iodoform gauze upon a roll, that I can pull out and take from it as much as I want without contaminating the rest of it, and place it back again.

I have been using for preparing the operation field soft soap, green soap; but lately I have been experimenting with the pure castile-soap shavings, which I think will clean the surface equally well, and will not, as I have frequently noticed, in preparing poultices for the operative field in abdominal surfaces, where soft soap is used, which contains so much potash, act as an irritant to the skin. Again, the soft soap is not always perfectly neutralized; either there is too much linseed oil in it or too much potash. Upon the other side of the lid I carry the mouth-gag, nail-brush, and razor. The razor is also placed in a little ducking case, so that as soon as it becomes dirty it can be washed and sterilized by boiling, the same as the rest of the outfit. In fact, every thing connected with this case is capable of being sterilized by heat; that is one feature that I have aimed at.

This is the mouth-gag that I carry, and for a nail-brush I use the cheapest nail-brush I can buy, one that costs me at the rate of fifty cents a dozen. I use it once and throw it away. I think it is much better to buy nail-brushes at five cents apiece, and throw them away, than to pay thirty-five cents apiece for them, and carry them for two or three months, and have them become septic and infected, which it is almost impossible to avoid after a nail-brush has been used a few times. The nail-brush also has another case of ducking, and also can be sterilized by boiling.

In this bottle I carry very fine, pure rubber tissue, and also on the outside a rubber dam for my drainage-tube. Have the rubber dam already cut with a hole in the center for the drainage-tube, and four openings for draw-strings to draw it together and pack it up with sublimate gauze; and in addition I have on the wooden reel more rubber tissue to cover the wound in the final dressing. I carry here rubber drainage-tubes of different sizes, and in this I carry decalcified drainage-tubes. I have but one more compartment left. In that I carry a twenty-five-per-cent solution of boroglyceride.

When you can not place away your instruments yourself, and have to intrust them to trained nurses or to others who are not careful, or do not understand exactly how to place them away, very often the box may become soiled or infected; and in fact I have seen some very unsightly operating-bags, but I have thoroughly protected this case by the use of a shell on the inside. I have two shells like this one that is exhibited, and as soon as the one becomes dirty I substitute the other. The shell stands of itself, and fits very snugly the inside of the case. When every thing is in the flaps are drawn over. Of course the shell is supposed to be full, and covers every thing up.

The disposal of the instruments has caused me a great deal of study. I have put a great deal of time on this, and I think now I have got the question finally solved. Every thing I have in this box is metallic or glass, with the exception of the handle, and therefore it can be subjected to heat. I can throw boiling water in this case and sterilize the whole as it is. I use this pan as an immersion pan if I am called away from the infirmary. It has no corners. Place a brick on each side, and with a spirit-lamp you can sterilize very readily. The instruments are disposed upon two frames, one resting upon the other. That is the first frame that I now show you. I carry two drainage-tubes, Hayes' saw, bone instruments, knives of various sorts, retractors, and hemostatics. The second frame is provided with a little shoulder, upon which rests the top of the frame.

You will notice that the instruments have been used from time to time very frequently, and you will see that they are a little brighter than it is customary to see them; but there is only one way to keep instruments bright as these are now. It is impossible to keep instruments highly polished by simply rubbing with any rouge you may employ. The way I keep these instruments bright is by means of a small jeweler's buffing lathe,

which can be purchased for a few dollars. With that you can always keep your instruments at a very high polish. The large box has no corners. They are filled so that it may be thoroughly cleaned.

In this glass jar ligatures are carried, etc., which I sterilize and keep in solution. In this long jar I have sponges and any dressings I may want to use. This is the irrigating apparatus for irrigating the interior of the abdominal cavity. I have this case for carrying the anesthetics.

Here is the ligature reel. This is another thing I have devoted a great deal of time to, and I think now I have got a ligature reel that fulfills all the indications and requirements. You see I carry nine different sizes of silk and catgut. These are arranged in the manner I indicate. The center piece projects into the ligature reel, and from the center piece I have side pieces going out, holding reels of different sizes to correspond with the character of the ligature material they are supposed to hold. In the largest I have braided silk for tying off abdominal tumors, and in the next I have the second size of silk for smaller tumors and adhesions. Then I have very fine silk for intestinal work; and I have three different sizes of catgut and two strands of each size.

Some of the advantages that I claim for this case are that it is complete, contains all the instruments necessary for any emergency operation, and the instruments are so arranged and disposed that they can be very readily rendered aseptic and kept so. I have seen operating cases which either did not contain sufficient instruments or contained entirely too many; the instruments were too cumbersome; and also the instruments and apparatus were so arranged that they could not be kept and carried in a perfectly safe condition. Now after the operation these instruments here are sterilized by boiling in soda solution and placed away. I have used them in abdominal work without any further sterilization, and have used them without any trouble whatever. But in order to make things doubly sure I always, if I operate where it is convenient to do so, sterilize them again before commencing the operation, so they are sterilized before they are put away, and then sterilized also before an operation is commenced, and in that way I am certain of getting absolutely sterile tools to work with. This ligature reel I have been using for some time. I have used this charge of silk and catgut in four sections, and have had no infection or any thing suspicious whatever to follow. The ligatures are sterilized by immersion in absolute alcohol; then the whole of the ligature reel is plunged in boiling water, and kept at the boiling temperature for five minutes. Next day this is repeated, and by this fractional sterilization I am certain that I get absolutely sterile ligatures. I also carry in the hypodermic case a syringe that I keep only to go with this case, and tablets of atropine, strychnine, nitroglycerine, and morphine.

Dr. Hume: What is the cost of the apparatus?

Dr. Schackner: I have not figured up exactly the cost of it. I spent a good deal in experimenting to get it to this stage. If I were to make another

I could do it much cheaper. Some of the instruments are imported, and some were purchased in Louisville and some in New York, and in that way were collected from different parts of the country and at different times, so I could not exactly answer the question intelligently.

Dr. Carpenter: The apparatus seems to be perfect as far as it can be made aseptic; but a man who is doing general surgery, abdominal and pelvic work, I think ought to have a different set of instruments for each kind of work. If he is going to do abdominal and pelvic work he ought to have instruments for that especial purpose; and then doing abdominal work, doing the best work, do that alone. Most bad results come from trying to do general and pelvic work; and I do not think we should run promiscuously into an outfit for all kinds of work.

Dr. Schackner: I think the argument is against the man and not against the case. You can put in the case what you like; you can take out your general instruments and confine yourself to abdominal instruments, or you can do *vice versa*. The instruments are sterile, and that does not argue any thing against the instrument case at all; but if any fault is to be found, it must be on the part of the operator carrying the infection otherwise, and not through the instruments.

Dr. J. M. Mathews, of Louisville, read the following resolutions:

Whereas, the superintendents and managers of the asylums for the insane in this State have reported from year to year an overcrowded condition of the several asylums in their care, and insufficient room to accommodate a large number of other applicants, who are not only deprived of timely treatment, but who are left in county jails or at their homes, at the peril of their own safety and the safety of their families and the public; and,

Whereas, such a condition of things is totally incompatible with the best interests of the public, whether considered from a financial or a sanitary point of view,

Resolved, That we urge upon the General Assembly now in session the importance of immediate provision for the relief at the hands of the profession which has ever had an open ear to the wants of suffering humanity.

Resolved, That we earnestly petition the legislature to enact the bill now before the Senate relating to the management of the insane asylums.

Dr. Wathen: I move the adoption of the resolution, and that a copy of it be sent to the legislature.

Seconded and unanimously carried.

The paper on Malignant Diseases of the Penis, by Dr. W. O. Roberts, of Louisville, was read by title.

Dr. Harry J. Cowan, of Danville, read a paper on Splenectomy for Scirrhus Carcinoma; Death from Shock. [See p. 24.]

DISCUSSION.

Dr. W. C. Dugan: In regard to the diagnosis of Dr. Cowan's case, we should say that a spleen weighing ten or twelve pounds would rather be against the idea of a scirrhus; and if it had been scirrhus, I do not think we would have found the patient in such a condition as was described. I would therefore be rather disinclined to confirm the diagnosis. The specimen was in rather a macerated condition when Dr. Frank received it, and that would make the diagnosis more difficult.

Dr. Cowan: There may have been a mistake in diagnosis, although the spleen was put in a chloral solution, for, as he says, the specimen was rather decomposed when it reached him. But it seems to me that leucocythemia is not in the history. There is no history of hemorrhage nor long wasting illness nor elevation of temperature—nothing that drew any clinical attention to the case, except that one single symptom directed to the left hypochondriac region, beginning with pain and ending with the formation of a tumor. Every thing pointed to that region alone from the beginning to the last; then, in the absence of other enlargements of the glands, in the absence of the history of hemorrhage or fever, we could positively exclude leucocythemia without any examination of the blood.

[TO BE CONTINUED.]

Pediatrics.

In Charge of Henry E. Tuley, M.D.

DR. D. S. LAMB, Pathologist of the Army Medical Museum at Washington, has an interesting article in the American Journal of Medical Sciences on Mecker's Diverticulum. He states that "it is single; it is usually at right angles to the small intestine, into which it opens, usually also on the convex side of the intestine; it is usually tubular in shape, but may be conical, globular, or inversely conical; its length varies from a very small size to as much as seven inches; it is usually found in the lower ileum, but is said to have been found in the higher part, and even in the jejunum and duodenum."

He reports one hundred and fifty-three cases, eleven of which are reported as from children and fetuses. He gives the length of small intestine of an infant as nine and a half feet; of the large, two feet. He quotes Osler as giving the frequency as two per cent. In conclusion he states: "As is well known, disturbances of digestion and serious danger to life have been caused by diverticula. They may be invaginated, and unless this is relieved death will follow. Foreign bodies may lodge in them and

set up inflammation and ulceration; sometimes perforation and fatal peritonitis. Typhoid ulceration may occur in them, and may be fatal. When they have a cord, the outer end of which is attached to some other part of the abdomen, this may cause strangulation of the intestine. Diverticula may lodge in hernial sacs and cause fatal disturbance."

The reviewer can add three cases: one, the diverticulum measured 6.5 centimeters; the other, 3 centimeters; the third occurring in a case of strangulated hernia, the diverticulum being found in sac, wedged in between two projecting coils of ileum, rendering reduction by taxis impossible, an operation for the relief of the condition being necessary.

LOCKWOOD (Archives of Pediatrics, June), from the observations in seventy-nine cases of measles in an institution, makes the following deductions: The period of incubation of measles is almost uniformly thirteen to fourteen days. Early vomiting and diarrhea are due mainly to accidental and extraneous causes. In considering prognosis it is important to distinguish between croupous and broncho-pneumonia. A rapidly fatal so-called pseudo diphtheria may supervene without affording any certain diagnostic clinical sign. Strict attention should be paid to hygienic details, as being more important than medicinal treatment.

BREMNER, of the New York Infant Asylum, reports the history of a case of purpura hemorrhagica, with autopsy, in an infant aged six months. Child was breast-fed, and in the four weeks previous to onset had lost forty-nine and a half ounces. Small purpuric spots appeared on second day, irregularly distributed over occiput, nose, shoulder, thighs, and legs. Hemorrhage from bowels on third day; vomited blood on fourth day, passing stools of pure blood on sixth day; death on seventh day, with temperature of 105°.

Autopsy showed cerebral hemorrhage of left side, broncho-pneumonia, area of congestion on anterior surface of stomach, and a recent effusion of bright red blood between serous and muscular coats at cecum. (Archives of Pediatrics.)

DR. CLARA E. DERCUM, in the Medical and Surgical Reporter for November, 1892, publishes a paper on the remarkable and fatal affection, purpura fulminaris. She gives a description of a case coming under her own observation, and has collected twenty additional cases from various sources. In the reported case, a little boy of four years, the subcutaneous hemorrhages were very extensive. There was epistaxis, but no loss from the mucous membranes. Death resulted on the eighth day. Of the twenty collected cases, nineteen occurred in young children, and one in a pregnant woman. Eighteen of these cases resulted fatally, three recovered. In fourteen cases there had been preceding illness, two followed pneumonia, three after scarlet fever, one after measles, one after whooping cough, two during

attacks of impetigo, nine after gastro-enteritis, and one was preceded by malaise. In one case the cow from which the child received its food had an abscess of the udder. The pus was noticed in milk, and no other food was given to the child. In one case a micrococcus was obtained from pure cultures from the affected tissues of the body, which reproduced the disease in rabbits.

The writer gives the results of an investigation regarding the etiology of purpura by Latzerich. This investigator had six cases under his immediate care. He revealed a bacillus from pure cultures from these patients, which when injected into rabbits caused purpura. While making these investigations Letzerich in some way became infected, and suffered from three successive attacks. During these attacks he had hemorrhage from gums, pharynx, nares, bronchial tubes, and intestines. There was very great enlargement of the liver and spleen, and purpuric spots on the skin and buccal mucous membrane. During these attacks he obtained from these purpuric spots the same bacillus obtained from culture experiments. He also obtained pure cultures from the spots, and reproduced purpura each time in rabbits. He infers from these experiments that purpura in all its forms is due to this bacillus, and that the different varieties depend upon the intensity of the poison and the resistance of the individual. (See *Canadian Practitioner*, November, 1892.)

DR. R. B. NEVITT also reports the following interesting case, with autopsy, in the *Canadian Practitioner*: A. T., a healthy, rosy, round-cheeked boy eight months old, was full of life and activity, taking his food well, and enjoying the best of health. The father is now in good health, but some years ago had an extensive operation on the nasal bones successfully performed. The mother has always been in good health. The child is the youngest of six children, who have all been well with the exception of the various exanthemata. About two months ago one of the elder children had diphtheria. The child had been well until 9 A. M., when it became dull and drowsy, and was evidently so sick that the mother, dreading an attack of diphtheria, sent for me. The drowsiness continued, the breathing became rapid, the skin cyanosed, the extremities cold. About 11 A. M. purpuric spots began to appear on the feet, wrists, and upper part of the thighs; later, they appeared on the forehead and scalp; some also were situated on the fingers and on the back between the shoulders. The spots were the usual dark purpuric spots, irregular in shape and size, not disappearing on pressure. There was one spot on the side of the tongue, one or two on the lips, and one on the palpebral conjunctiva. The spots continued to appear in the various localities named, and some few on the chest and abdomen. The child continued to try to nurse, but was prevented by weakness and growing restlessness from sucking more than a short time. The cyanosis deepened, the breathlessness increased, and the child died at 2 P. M., after an illness of only five hours. At the examination held twenty-four hours

after death the head was not examined. The thoracic and abdominal viscera appeared healthy and normal, with the exception of the kidneys, which had purpuric spots under the capsule, not in the gland tissue. The right supra-renal gland contained a large black clot of blood, which distended the hat-shaped gland. The bladder contained about two ounces of clear, limpid urine. The spleen was healthy, and normal in appearance and size. There was a small supernumerary spleen dangling at the end of a long pedicle.

O. E. TCHERNOMORDIK, of Tschashniki, relates (*Vratch*, No. 4, 1892,) the case of a normally developed and generally healthy girl who has been regularly menstruating since February, 1891, when she was not quite one year old. The hemorrhage recurs every four weeks, lasting on each occasion four or five days, and being accompanied by occasional pain about the hypogastrium. The first menstruation was preceded by some fever, an urticaria-like rash over the whole body, and general restlessness lasting for three days. The symptoms subsided with the appearance of the bleeding. The girl's mother is somewhat nervous, but otherwise healthy. She began to menstruate at about the age of fifteen. (*Canadian Practitioner*.)

DR. T. H. SOUTHGATE (*Archives of Pediatrics*, June,) reports a case of scurvy in breast-fed infant, with an analysis of mother's milk, and the blood state given. Child had a strong tuberculous history. A gastro-intestinal disorder developed, which improved under salol, given in two-grain doses every two hours. Simple anemia was one of the most striking features of the case. After the administration of anti-scorbutic diet, begun January 25, 1893, hemoglobin increased from thirty per cent on that date to seventy per cent on March 20th, with a proportionate increase in red blood corpuscles. Analysis of mother's milk showed

| | |
|--------------------|-----------------|
| Water, | 87.20 per cent. |
| Fat, | 4.50 per cent. |
| Caseine, | 2.10 per cent. |
| Sugar, | 5.07 per cent. |
| Ash, | .02 per cent. |

Reaction slightly alkaline.

CHOLERA.—During the first week in June epidemic cholera appeared at Mecca, and increased rapidly. Last year this hole of pestilence escaped; but it will be remembered that in 1891 faithful Mohammedans died of the disease by the tens of thousands. In France, where, since the outbreak at L'Orient and Quimper in April, the reports have been encouraging until the past week, cases have been discovered in Toulon, Cette, and Narbonne.

THE AMERICAN PRACTITIONER AND NEWS.

"NEC TENUI PENNÂ."

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No. 1.

D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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REPORT YOUR FAILURES.

It would in all likelihood be impossible to frame an injunction out of any other three words in the language that, if followed, would inure in an equal degree to the advancement of knowledge. If one traces out the steps in the discovery of almost any truth from the earliest dawn it began to be shadowed forth, he becomes lost in the mazes of the long and intricate history. Take, for instance, the process of combustion and the resulting development of heat, and trace it through all theories of phlogiston, caloric, and the like, and what mountains of volumes might be gathered to whose production the question has given rise! And this, it is to be remembered, is a question of pure science, not handicapped with any art to entangle it in bias and impede its progress. Sloth and vanity alone have here been hindering forces; sloth from the want of philosophical stimulus, and vanity that tended to chain men to the first position they might happen to take, and thus prevent further fruitful use of their talents. But when to indolence and vanity are added self-interest, the establishing of a truth becomes incomparably more difficult.

With every year, with every month, and almost with every day, some doctor starts on the rounds the report of an experiment in therapeutics that has given good results. Thanks to the vast room there is for improvement in therapeutics, others readily take it up. If it fails, all right; nothing further is said about it by any of the new experi-

menters; but if the use of the measure happens to be coincident with success, each observer adds his voice to the volume of favorable report, and thus it results that often a whole country, and sometimes the whole civilized world, is led into error, until each physician by his own individual experience is led to discover the utter worthlessness of the measure. Suppose that from the first each one who failed with sulphuretted hydrogen or the pneumatic cabinet, or beech-wood creosote, or tuberculin in consumption had published all his failures, does any one believe these fads would have lasted two months, or would have gone beyond the walls of the charity hospitals? And so with the whole tribe of fads, and with various measures that hardly deserve even so unsavory a designation.

If failures were published with as much assiduity as successes, the career of all errors would be shortened, and more progress would be made in the right practice of medicine in one year than is now made in twenty. Let us all sum up courage, then, and report truthfully our failures and our blunders; in no other way can we do so much good in our day and generation.

PASTEUR'S HYDROPHOBIA CURE A FAILURE.

At a recent fête organized for the express purpose of honoring the illustrious savant, no less a personage than Sir Joseph Lister, who was one of the principal orators, felt constrained to declare that if M. Pasteur had been prematurely credited with having found a definite cure for hydrophobia, the fault lay with his eager admirers, and not with himself. This is a virtual surrender of the entire question, the claims of the system now being abated to the conferring of immunity against the bite of mad dogs by previous inoculation, for certainly the whole world, born and to be born, will take the chances of getting bitten before being vaccinated. The admission, coming at this time on the heels of the surrender of so many of the claims of chemical antisepsis, is not only startling in itself but is amazing in its far-reaching implications and the lessons it conveys. It is unfortunate that we can not go back to the methods of those who discovered that the human anatomy is not what Galen taught it was, and who declared that men's anatomy had changed, since the master must have been right. It would be

complimentary to human reason and sustaining to human testimony hereafter, if we could say that owing to some influence not yet discovered the constitution of things has altered, so that effects had yesterday can not be had to-day by the same methods.

Through all its career two men of eminent position have contested the validity of Pasteur's methods. These are M. Luteaud, of the *Journal de Médecine de Paris*, and M. Peter, of the Academy of Medicine. They were charged with envy, with pig-headedness, and with various sinister motives, and at all events they were left for a long time to stand chillingly alone. They showed conclusively that, if Pasteur saved as many lives as his friends claimed, he saved six times as many each year as had ever been known to be lost in one year by hydrophobia in France, while in the mean time as many died each year as by any sort of a fair calculation the country could have had in the like period. They kept a "Pasteurian necrology," and reported the returns from all the departments showing the deaths after anti-rabic inoculation, these returns being official and evidencing numerous failures. These undisputed statistics could lead to but one conclusion, viz., if Pasteur's treatment saved lives, they were the lives that the treatment itself had endangered.

It will be remembered that a commission of eminent names was sent over from England to investigate the claims of Pasteur's system, who reported it a success, and it will be remembered too that severe contumely was visited upon those who in England spoke unfavorably of the results of the inoculation. They fared little better than those who refused to recognize in all their fullness the claims of corrosive sublimate. And now that the author of the claims of chemical antiseptis, who has been always honest and always fair, should rise up and confess for himself the failure of his own pet system, and then for Pasteur the failure of his marvelous plan of protective vaccination against hydrophobia, it is enough to cause us to think that sanity or insanity is indeed a matter of majorities. In very truth it is the turn of the alienist, or, at all events, the psychologist, to inquire about the way in which judgment could have gone so strangely awry. An anti-rabic epidemic, such an epidemic as more than once has seized France, seems to have sprung up in that receptive, responsive land, and extended to the rest of the world.

Nor are the laurels won from battling with hydrophobia the only ones that rest on the shoulders of that truly great man in trembling

insecurity. Nothing is more certain than that his supposed remedy for the silk-worm blight and the grape blight, and many other measures for which he has credit, rest upon no more secure foundation. Notwithstanding the *quasi* ridicule with which Ernest Hart, in his able address on cholera before the recent meeting of the American Medical Association, treated the idea of obscure or so-called epidemic influences, we all know that the equivalent of such influences is constantly in operation. We all know how that one year the farmer has smut in his wheat, and the next year none; how for two or three years together oats will be spoiled with rust, and then for many years will be free. We know that for years in a large section of this country the raising of grapes had to be abandoned by reason of a blight that has disappeared of itself or become greatly modified. We know that the grasshopper or locust, after a period of several years of quiescence, multiplies to inconceivable numbers, migrates widely over the land, and then again disappears, to repeat in another like cycle the same phases of its history.

Whatever the cause, cycles are distinctly shown in the vigor of various forms of life, both animal and vegetable. When the time of the oidium was up, when the cycle of the silk-worm pest had about made its round, and it was ready to go, Pasteur fortunately threw his sword into the scale and the beam went up. But time was a silent partner in the firm, and an indulgent people waited very patiently for the silent partner to get in his perfect work.

While these things have been taking place in the Western World, a similar scene on a much smaller scale has been enacting in far-away Japan. Dr. Takaki introduced into the Japanese navy a modification of diet for the sailors, just at a time when kakké or beriberi prevailed extensively, and in a short time the disease disappeared. The good doctor was thereupon ennobled by the government. Now, however, it has been conclusively shown that kakké goes by cycles, and that the changes introduced by Dr. Takaki were a mere coincidence.

These experiences teach two important lessons. First, they prove that the discoverers of beneficent forces will be duly rewarded, and that thereby those who are properly gifted will be stimulated and encouraged to exert their powers. In the next place, and mainly, they show that the severe methods of exact science, and even positivism, are to be kept closer in view in the future, in the investigation of medical questions, than they have been in the past.

Special Notices.

DIARRHEA IN CHILDHOOD.—For a child one year old give:

- R Kennedy's Extract *Pinus Canadensis* (dark), 3 drachms;
 Acid nit. mur. 5 drops;
 Syrup orange peel, q. s. ad., 2 ounces.
 M. Sig: Teaspoonful every two or three hours.

SALOPHEN IN ACUTE RHEUMATISM AND INFLUENZA.—The winter of 1892-3 has, from a medical point of view, a marked peculiarity: It has been characterized by a larger number of cases of influenza or *la grippe* than almost any preceding winter, and yet less has been said concerning influenza *per se*. The vogue of *la grippe* having ended through tiresome repetition, the tendency now is to ignore it altogether. An advantage of this mode lies in the fact that common colds and pneumonites are no longer huddled into the *grippe* group. But influenza is a terrible entity, and will so remain. The swift and potent adynamia is not so characteristic of the known acute fevers as it is of this condition, which has raised the death-rate of England by two per cent. There seems to have been no effective new therapeutic agent employed in Influenza except Salophen, and this has been for this condition frequently combined with Phenacetine in equal parts. Thus prescribed these remedies are said to have especially been very effective, and this was especially the case when any rheumatoid complication was present. Of the value of Salophen with bicarbonate of soda in acute rheumatism the evidence is now very large, and it is probable that Salophen will be regarded as our most effective antirheumatic. The characters of Salophen are such as to demand for it a very extended trial. Its salicylic component is combined with a phenic derivative, which is so well bonded chemically that its full therapeutic effects may be had without the danger of toxemia. Hence the remedy may be given continuously in large doses, and the cure assured. Where the pain and fever of acute rheumatism are especially severe, Salophen may be united in equal parts with Phenacetine as referred to above in speaking of the treatment of influenza.

IMPOTENCY.—A reliable remedy.

- R Tincture sanguinariae, 1 oz.;
 Extract stillingiae, fl. 1 oz.;
 Celerina (Rio), 6 oz.
 M. Sig: Teaspoonful four times daily.

SALIPYRIN IN MENSTRUAL DIFFICULTIES.—Burtscheid (*Deutsche Medicinal Zeitung*) obtains excellent results from salipyrin in excessive menstruation and in menstrual difficulties, even in the climacteric age, when the trouble is not dependent on severe organic disease of the uterus. When used at the beginning of the period, salipyrin proves superior to preparations of ergot and hydrastis, as it materially reduces the duration and the quantity of the flow. He gives

- R Salipyrini, 1.0 (gr. xv).
 D. lal. dos. xii in capsul. amylac.
 S. One three times daily.—*Condensed Extracts*.

DIABETES INSIPIDUS:

- R Extract ergotae fl. 1 oz.;
 Kennedy's *Pinus Canadensis* (dark), 1 oz.;
 Extract valerian, fl. 1 oz.
 M. Sig: Teaspoonful three times a day.

THE
AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNĀ."

VOL. XVI.

LOUISVILLE, KY., JULY 29, 1893.

NO. 2.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

ERGOT IN LABOR AND ABORTION.*

BY F. M. GREENE, M. D.

The art of obstetrics has kept fully abreast of all other branches of medicine, and we find that new modes and new remedies have taken the place of the old. Antiseptic midwifery has taken its place beside antiseptic surgery, and the accoucheur who now enters the lying-in chamber must observe all the rules of antisepsis, of which cleanliness forms an important part. Clean in his hands, person, and apparel, he will perform no operation nor allow any instrument to come into contact with the patient's body which has not been properly sterilized. It is of no less consequence that the parturient herself shall be clean, in her bed and bedding, and a bath, to be followed by a carbolic acid or corrosive sublimate vaginal injection, must immediately precede her accouchement.

That cleanliness alone is not sufficient, was proven less than half a century ago in the celebrated case of Dr. Rutter, of Philadelphia. Puerperal fever had followed in the wake of this distinguished obstetrician until he left the city in disgust, and was absent for some time. On returning to the city, and previous to visiting his patients, he had taken a bath, had his head shaved, and all his apparel made new. The very first patient whom he attended in her accouchement had puerperal fever. Dr. Meigs, his contemporary, would believe that the disease resulted "from the providence of God," rather than conta-

*Read at the May meeting of the Kentucky State Medical Association, 1893. For discussion see p. 65.

gion which might be conveyed by the hands of the physician. The case of Dr. Rutter marked a new era in the history of obstetrics, and notwithstanding his observance of the rules of cleanliness he labored under an ozena which may have been the source of infection. Gemelweis demonstrated that puerperal fever was identical with septicemia, and was frequently conveyed on the hands of the accoucheur and attendants. Through antiseptic midwifery, maternities which were believed to be centers of contagion were made asylums of safety.

In the management of the different stages of labor we find as great a change. Not only many of the old time remedies, as blood-letting and nauseating doses of tartar emetic have been discarded, but the warm bath and ergot have in a great measure been laid aside, and are now placed in the limbo of obsolete remedies.

In this paper we propose to discuss the real therapeutic value of ergot in labor, and the conditions and treatment of those cases in which it has been supposed to be indicated. First, in prolonged second stages of labor, in which "the head being born in the pelvis, pains absent, and there may be danger in delay from hemorrhage or other complication," inertia is the most frequent cause of delay, and is itself dependent upon so many conditions as to be common in both multiparæ and primiparæ. Among them we recognize rigidity of the os, by which the first stage is greatly prolonged, malposition of the fetus, displacements of the uterus, multiple pregnancy, and hydramnias. Each of these conditions will require its appropriate treatment, and it must be rare that ergot would be required in any of them. In multiparæ there might be little danger, provided the parts are properly dilated and the labor so nearly completed. In primiparæ it would be hazardous, from the fact that we more frequently meet with delays at the outlet from rigidity of the perineum. If the complication be *ante-partum* hemorrhage when the indication is to speedily empty the uterus, we have a better and safer remedy in the forceps, which are more under our command.

The objections to the use of the remedy are as follows: First, in the ordinary doses of one teaspoonful of the fluid extract it will often produce tetanic action of the uterus, which is at once beyond our control, and the labor unduly hastened, producing tears of some portion of the genital canal or rupture of the perineum. Those who have witnessed the sad results which have sometimes followed the use of ergot will appreciate this danger. Infant mortality under the use of ergot

has been shown to be large, and Hardy, of Dublin Lying-in Hospital, found that in thirty cases of lingering labor in which it was administered, ten, or one third of the infants perished.

The dangers to the infant were two-fold. First, tetanic action, by which the regular rythmical contractions are interfered with, and it perishes from asphyxiation. Secondly, through the maternal circulation it has a direct toxic effect upon the heart of the infant. The recent experiments of Hernmater, of Johns Hopkins University, Baltimore, have thrown great light upon the physiological action of the drug when given in minimum doses, and upon the result when given in toxic doses. These experiments were performed upon the lower animals, but established the following facts: Whether given *per anum*, hypodermatically, or injected into the venous or arterial systems, the results were the same. First, "it produces contraction of involuntary muscular fiber throughout the system." By contraction of the "arteries and arterioles it causes a rise of blood pressure; it reduces the number of pulsations of the heart within a given period, also the number of respirations; its action is central through the central nervous system, and not peripheral." It was not formerly supposed that the noxious properties of the drug were so great as to have destroyed the fetus through the circulation of the mother, and the result was rather ascribed to pressure, either upon the fetal head in its passage through the pelvis, or upon the funis and placenta by continuous action.

As a substitute for ergot, and also the forceps in cases of delay from inertia, we have a simple means in pressure, both effective and of easy application. It may be used in the first stage, when the uterus is acting feebly, and toward the close of the second stage, when dilatation is almost complete. These difficulties were often met formerly by venesection, nauseants, the warm bath, and more recently the forceps. The indications for the use of pressure must be the same as for ergot and forceps, a proper degree of dilatability of all the parts. In cases of delay from rigid os or perineum it is even more effective when preceded by chloral hydrate or antispasmodics. This mode is not new, but has been brought prominently before the profession by Kristiller under the name "*expressio fetus*." He claimed that with a capacious pelvis and proper dilatation the fetus might thus be expressed especially without the aid of contractions. In this connection I refer to the following case of *ante-partum* hemorrhage, which was treated successfully by Kristiller's mode of pressure. The notes are taken

from my case book, and more fully reported in the January number of the Medical News of Philadelphia for 1892.

Mrs. M. had advanced only to the beginning of her ninth month of gestation. A normally situated placenta was probably entirely separated by a fall, and the external hemorrhage which soon followed was not sufficient to produce the syncope and profound shock which ensued. Her symptoms were those of concealed hemorrhage. I was called suddenly without knowing the nature of the case, and without an obstetrical outfit save ergot and a hypodermic syringe. A clot was turned out of her vagina; the os found open to the size of a dollar, membranes slightly protruding, and vertex presenting. Hemorrhage had now ceased, and a binder was drawn around the abdomen with firmness. After waiting a short time for my forceps, syncope was again threatened, when the patient was placed in position for podalic version, the bandage loosened and pressure applied with both hands over the uterus. The pressure was made, gently and intermittently at first until it brought up contractions, and the labor was soon terminated. The patient had already lost blood to a great extremity, and was thus saved from further shock from version or the use of the forceps.

The next indication for the use of ergot is in puerperal eclampsia, when convulsions have set in and pains are wanting. Inertia is not often a complication of eclampsia, hence the uterus usually partakes of the general spasms. In these cases infant mortality must be great, from the intensity of the spasms or asphyxiation. Ergot could be of use only as an ecboic, and the forceps or pressure are to be preferred. In comparing his old and new methods of treatment of eclampsia it is proper to state that its precise pathology has not even at the present time been determined.

In 1842-3 Rayer and Lever called attention to the excess of albumen found in the urine of eclamptic women. We have also the theories of anemia and of hydremia, and of retention of urine and other substances in the blood. The older theory of the apoplectic origin of puerperal eclampsia has in a great measure been abandoned, and its "sheet anchor," the lancet, laid aside. There is perhaps no affection requiring greater discrimination in treatment than eclampsia in the parturient. While each practitioner will be guided by his own favorite theory, absolute symptoms are not to be overlooked. Thus, throbbing of the carotids, coma, and cyanosis are best met as formerly by venesection. In weak and anemic patients with small pulse, and in whom the nervous and

hysterical element predominates, we may more safely adopt the anesthetic or sedative treatment.

The late Fordyce Barker pleaded for the restoration of the lancet in puerperal eclampsia. Paget does not admit of its dependence upon albuminuria, and treats it antiphlogistically. Viet and many other distinguished obstetricians treat it by prolonged narcosis. The first indication must be to rescue our patient, if possible, at once from the existing congestion of the brain and spinal centers, and this may be accomplished more speedily by venesection than any other means. Nor should the fact that the third stage must be accompanied by the loss of more or less blood deter us, since we have so many means of controlling this form of hemorrhage.

The two remaining conditions in labor in which ergot may be indicated are retention of placenta and *post-partum* hemorrhage. As the latter is so frequently dependent upon the former, they will be treated of together. The causes of retention are recognized as irregular or hour-glass contractions, abnormal adhesions, and simply inertia. There could be no indication for the use of ergot in abnormal adhesion, since for detachment and removal of the placenta the hand or curette may be required. Irregular or hour-glass contraction may doubtless be sometimes produced by ergot by causing contraction of the lower segment of the uterus as far as the internal os, which is constricted, and the fundus is unable to contract, owing to the presence of the placenta. Since placental delivery has elicited much interest lately, and has been termed a miniature labor of itself by some, it will be proper to refer to its natural mode of delivery, as when accomplished by contractions of the uterus alone.

In muscular, healthy patients, with the uterus acting vigorously, careful observation, I think, will show that the placenta is for the most part partially and sometimes wholly detached by the last contraction which expels the fetus. If hemorrhage occur in the least quantity or at all, unless it proceed from tears of some part of the genital canal, it is an indication that the placenta is at any rate partially separated. It was the rule of the older obstetricians to wait, unless the hemorrhage was alarming, until the uterus again arouses itself to action. If there was no hemorrhage, the time which we were to wait varied from one to two hours. No stage of labor can be of greater importance, since the life of the mother will often depend upon a correct management of this stage.

We leave to the physiologist to determine the precise mode of the detachment of the placenta, and as to whether the process begins centrally or peripherally, but the *time* of its separation is of great importance. Bourdelocque, Tanner, and others taught that "it sinks to the os by its own gravity" and "presents first by its fetal surface." Observation shows that it frequently presents first at the os by its maternal surface, when left to be expelled by contractions, without the aid of artificial measures. Traction upon the funis, especially before it has left the uterine cavity, would cause the former presentation, and it is doubtless often caused in this way by attempts of the accoucheur to remove it *vis a fronte*. Preternatural shortness of the funis or coiling around the fetus is sometimes a cause of dystochia, and I recently witnessed a case in which it was dragged externally by the fetus, and an alarming hemorrhage immediately followed.

Post-partum hemorrhage is regarded now as a preventable accident, and in every case in which hemorrhage has accompanied or immediately followed the birth of the child we should proceed to its delivery, after having cared for the infant. If there is no hemorrhage, I see no reason, as Milne, of Edinburgh, terms it, for "waiting around the lying-in chamber two or three days for the expectant case to turn up." If adherent, it is not probable that time or ergot will expel it, and the latter might seriously embarrass the introduction of the hand or instrument for its removal. The mode by pressure will often be found to succeed, and especially if the placenta has been partially detached. This mode by pressure, now called Crede's mode of expression, has recently caused much discussion between his followers and those who adopt the expectant plan.

The difference of opinion probably arises from a misunderstanding on the part of the latter of the real mode of expression. Ashfeld, Cohn, and others oppose the mode, and contend that it absolutely favors *post-partum* hemorrhage, and would lengthen the interval between the second and third stages of labor. I do not think that the charge that this is forced delivery is just, since by these means the uterus itself is simply induced rather than made to expel the placenta. It is from inertia that we so often meet with delays in delivery of the placenta, and it comes on at a most inopportune time, when the placenta has been partially detached and the uterus remains suddenly relaxed and quiescent.

In all cases of lingering labor, or in which hemorrhage may be anticipated, the pressure should be commenced before the birth of the

infant, and at any rate during the last contraction which expels the fetus. It is important that an intelligent assistant make the necessary pressure at this time, and that it should be continued afterward for some time, for the reason that frequently while our attention is taken up with the child alarming hemorrhages occur.

Lastly, we come to consider the use of ergot in abortion, and preface our remarks with this text from Prof. Engelmann, "Ergot should not be used in abortion until after the uterus has been emptied, and as long as the ovum or any of its parts remain adherent *in utero*." In the treatment of abortion, when it has been decided that the ovum must be lost there are few practitioners who will not continue to regard ergot as a most valuable remedy in many cases. As long as we may hope to preserve the ovum, prophylactic measures are of the utmost importance, and ergot, on account of its ecbotic character, should not be given. Rest, opiates, chloral, the bromides, and especially viburnum prunifolium, are valuable only as preventive measures.

Inevitable abortion must be met by more active treatment. Whether it occur during the first trimester, and before the period of placental formation (abortion proper), or during the second trimester (miscarriage), or after the fetus has become viable (premature labor), the process must be completed as soon as possible, and temporizing measures are no longer indicated. There are perhaps no cases more trying to the patience and skill of the physician than these cases of early abortion.

The difficulty of ascertaining the precise condition of the ovum may not always be determined by the most careful examination. When the hemorrhage has been considerable, and is accompanied by rythmical contractions of the uterus, the patient will generally abort.

A distinguished obstetrician, Dr. Meigs, of Philadelphia, taught in his lectures that, as a rule, if a woman who is pregnant lose a teaspoonful of blood from the uterus she will abort. While with many this may be true, experience teaches that a much larger quantity is lost and the ovum sometimes preserved. The uterine sound has been frequently introduced into a pregnant uterus, and the ovum afterward preserved. Many distinguished gynecologists treat abortion in the earlier months precisely as they would treat abnormal growths or tumors. The indication with them is to clean out the uterus at once, whether the foreign substance be a polypoid, decidua, or thickened placental tissue.

The average practitioner will perhaps continue to adopt the expectant plan in many of these cases of early abortions. If before the period of placental formation, and the hemorrhage be threatening, and we can not explore the uterus with the index finger, there are two modes which we may adopt to produce proper dilatation, the sponge, tupelo, or sea-tangle tent, or rapid dilatation by the Steele dilator. I have always been disappointed in the use of the rubber bag or colpeurynter to produce dilatation. The vaginal tampon seems peculiarly well adapted to these cases, and if ergot be given immediately after its introduction it will rarely disappoint us, both in controlling hemorrhage and in producing sufficient dilatation.

The most troublesome cases occur during the second trimester, where after the ovum has been discharged the placenta and membranes remain behind. At this early stage of its development the placenta is not easily removed by contractions alone, and should we adopt the expectant plan we submit our patient to all the dangers of septicemia. Ergot might control hemorrhage by closing the uterus, but could not cause the placenta to be discharged, and if continued would cause the case to be prolonged indefinitely.

In any case where the finger or hand may be introduced it would be better at once to remove the placenta, secundines, and all debris. The old-time remedies, rest, time, and laudanum will not answer here, and modern gynecologists do not hesitate under proper antisepsis to remove the placenta with the curette.

Modern antisepsis has thus rendered operations harmless which were formerly regarded as extremely hazardous. After the seventh month (premature labor), when the uterus will admit the introduction of the hand the tampon and ergot may be both contra-indicated, as by the former sufficient blood may be dammed up in the uterus as to prove fatal, and by the latter the placenta may be imprisoned, and especially since at this time it is detached with greater difficulty. Pressure, which is not so available during the first and second trimester, may now render valuable assistance, and even supersede the use of the forceps, ergot, and other ecbolics.

Finally, in the administration of ergot I call attention to the conclusion of Shatz in regard to the physiological action of the drug: "The action of secale begins fifteen minutes after its administration by the mouth, and is greatest in thirty minutes. The effects of a dose last for one hour only, and the drug must therefore be repeated hourly."

It will thus be seen that the ordinary dose of one teaspoonful of the fluid extract, and repeated every fifteen minutes, will in most cases produce tetanic action of the uterus, and is therefore too large. Recently I had sent me a preparation known as ergotole, and which I found effective in doses of eight to ten minims *per ore*m.

GREENEDALE, KY.

THE NASO-PHARYNX IN MEASLES AND SCARLET FEVER.*

BY J. A. STUCKY, M. D.

We are all familiar with the appearance of the pharyngeal inflammation accompanying measles and fever, and any attempt of a description of it by me would be perhaps a waste of time.

It is to the naso-pharynx and post nasal cavities in these diseases that I direct special attention.

Several years ago, in the St. Louis Medical and Surgical Journal, I claimed that in the large per cent of cases where the pharynx required medical or surgical treatment, the naso-pharynx or post-nares required as much or more. I still hold the same view.

The naso-pharynx is mentioned in connection with the exanthemata of measles and scarlet fever, because within the last few weeks my attention has been called to the need of closer investigation and treatment of this important part of the superior respiratory tract in acute troubles. The results of my observations in seven cases of measles (five were in adults) and three of scarlet fever (in my own family) has been somewhat of a revelation to me, and leads me to claim for, and to urge equal, if not more attention to the naso-pharynx than to the lower pharynx.

The sequelæ of the two diseases mentioned that I usually meet with are, (1) suppurative otitis media, (2) catarrh of the eustachian tube and tympanic cavity, (3) pharyngo-nasal catarrh, simulating usually the hypertrophic variety.

Until several months ago I do not recall having ever examined closely, with the rhinoscopic mirror, any case of measles or scarlatina. In the ten cases referred to the result of the naso-pharyngeal examinations (rhinoscopic) showed the severity of the naso-pharyngeal inflammation to be in direct ratio with the pharyngeal, which is usually in

direct ratio with the severity of the general affection. In other words, a severe pharyngo-tonsillar inflammation means a similar condition of affairs in the pharyngeal vault, and extending into the post-nasal spaces, gradually subsiding in severity toward the anterior nares.

In consulting some of the leading authorities I find little or no mention of care or treatment of the naso-pharynx in these diseases.

I believe it may be stated as a fact that pharyngeal inflammation more frequently extends upward than downward, because, (1) "the soil is more inviting," (2) more glandular structures, (3) the spongy tissues, and more vascularity. Bosworth, in writing on this subject, says: "Pharyngitis rarely shows any tendency to extend into the trachea and bronchial tubes unless the respiratory function of the nose is impaired. When, however, the mucous membrane of the upper pharynx (naso-pharynx) is involved in acute inflammation, we can easily understand how symptoms referable to the ear should in most cases be a prominent symptom, owing to the extension of the inflammation to the orifice of the eustachian tube, resulting in a temporary stenosis with impairment of the hearing, etc. The rhinoscopic mirror shows the vault of the pharynx presenting the same turgid condition as the pharynx."

Politzer, writing on the same subject, says: "In acute naso-pharyngitis frequently the mucous membrane covering the posterior extremity of lower turbinated (spongy) bones swells so considerably that it protrudes above the posterior nares, partially fills the pharyngeal vault and covers the orifice of the eustachian tubes so that ventilation of the tympanic cavity is obstructed."

This condition was observed in two of the cases of measles I had.

Cohen, writing on sore throat of measles, says: "We have catarrhal inflammation affecting the air-passages, from the nostrils to the bronchi. Its severity is often in direct ratio with the severity of the general affection. The eustachian tubes sometimes become involved in the catarrhal inflammation and there may then ensue impaired hearing or marked deafness, accompanied by acute pains in the ear." Further, he says: "Sore throat of scarlet fever is often of a severe character, and apt to leave permanent injury, especially of the eustachian tubes and middle ear." And then he declares there is "no difference from ordinary sore throat, save more frequency of swelling of lymphatic glands, except in the anginose variety, where symptoms are more violent, and we have copious deposits of pseudo-membrane on tonsil, palate, and palatine folds."

Mackenzie says: "Pharyngitis of measles, usually of slight importance, but sometimes accompanied by severe rhinitis, and in these cases epistaxis frequently occurs followed by dry catarrh and ozena, occasionally ulceration of the septum nasi." He also says the "recognition of scarlatinal pharyngitis is principally based on the existence of the skin eruption during some period of the illness. The suddenness of the attack, intensity of the accompanying fever, the deep red or violet tinge of the pharynx, and the occurrence at the same time of an epidemic of scarlet fever, all tend to assist in the diagnosis; but when the pathognomonic exanthem is absent some uncertainty must often remain as to the true nature of the malady. In such cases the subsequent development of dropsy and albuminuria occasionally set any doubts at rest."

As to any uncertainty of the diagnosis of scarlatinal angina without the eruption, I am now fully convinced. Nine weeks ago my little boy, aged eight years, was taken with a chill, complained of his throat, which was quite red, soon developing into a "follicular pharyngitis," which in twelve hours I diagnosed as scarlatinal angina; there was glandular enlargement, and all the symptoms of scarlet fever present except the eruption. Dr. Barrow saw him with me in the evening of the second day of the attack, and differed with me as to diagnosis, believing it simply a violent case of pharyngitis. In four or five days the little fellow was all right, no sign of eruption having made its appearance, though so certain was I of my diagnosis, I closely watched for it.

In one week my little girl was taken in the same way, and in thirty-six hours the typical eruption of scarlatina, covering her entire body, made its appearance. Drs. Barrow and Bullock, who saw her for me, then concluded that undoubtedly the little boy must have had the disease without the eruption, but in eight days from the time the little girl was taken, and two weeks from date of the little boy's previous attack, he was taken in the same way, chill, sore throat, and vomiting, and on second day the eruption made its appearance. The disease ran its course without any complication. This case is reported to illustrate the truth of the adage, "we can't most always tell," especially when the pathognomic symptom is absent.

Dr. Mackenzie concludes his article on these diseases with the statement: "Local treatment is of but little use in the treatment of scarlatina angina or agina of measles." The same might be said of any treatment of these diseases. The physician simply endeavors to guide the disease,

both constitutional and local, to a safe termination, only interfering when complications arise. I have given at some length the views of a few of the leading authorities on inflammation of the pharynx and naso-pharynx, in order to emphasize the importance of the topic under consideration.

One of the most important sequæ of these diseases is ear trouble and nasal catarrh, yet not one mention is made of any special treatment toward preventing extension of the inflammation to the eustachian tube, and through it to the tympanic cavity. In five of the cases of measles I saw I was called on account of earache, in the other two on account of laryngeal complication. In each case, especially of the five referred to, the pharyngeal inflammation was of a severe type, complicated with plugging up of numerous follicles with a cheesy substance; nasal respiration was greatly impaired or completely obstructed by turgid, swollen membrane.

After cleansing the pharynx and painting with a weak solution of cocaine, the rhinoscopic examination was made without difficulty, and the same degree of inflammation found in the pharynx was also found in the naso-pharynx.

In three cases the orifices of the eustachian tube were plugged with mucous. In two of the cases a four-per-cent solution of cocaine had to be used in the nasal cavities in order to reduce the turgescence sufficiently to allow of nasal respiration. In one case the inflammation had so involved the tympanic cavity as to result in suppuration, which necessitated puncturing of the tympanum.

The only indication for treatment in any of the cases, and all were much alike in appearance, was (1) to keep the parts clean, (2) to allay irritation. This was accomplished by means of five- or ten-per-cent of peroxide hydrogen in mild alkaline solution containing one or two grains of cocaine to the ounce, sprayed first in the pharynx, then into nasal cavities (nostrils) every two or three hours until the nose was thoroughly cleansed and nasal respiration was restored. The spray was used (with patient's head thrown back) until it ran freely into the mouth, thus cleansing the nasal cavities, orifices of the eustachian tubes, and softening and freeing much of the secretion in the naso-pharynx. In every case the patient expressed sensation of relief to the ears when both nasal and pharyngeal cavities were thoroughly cleansed.

The same treatment was used with my children with scarlet fever, one of whom suffered with his ear, and was threatened with tympanic

abscess, but I believe it was prevented by attention to the nasal as well as the pharyngeal cavity.

This treatment can be used without difficulty on the youngest patient, only a little time and patience being required to convince the child that it will not hurt. The solution used must be non-irritating and soothing.

LEXINGTON, KY.

IS EXCISION OF CHANCRE A JUSTIFIABLE OPERATION?*

BY O. H. REYNOLDS, M. D.

It is nearly twenty years since Sigmund demonstrated the fact that cauterization of the point of inoculation of syphilis, if done within three days from the time of inoculation, was competent in many cases to prevent the development of the malady. A step further in this direction is the prophylactic destruction or excision of the initial lesion itself, and it was not until ten years afterward that marked attention was drawn to the subject by Auspitz's publication of thirty-three cases in which the initial lesion of syphilis had been excised in the hope of thereby preventing any further manifestation of the disease.

Many of the younger German writers, convinced that the primary lesion of syphilis is entirely local in its nature, insist upon the possibility of arresting the progress of such infection by early and thorough excision of the initial lesion before the development of inguinal buboes. Not a few are also of the opinion that in those cases where the removal of the primary lesion fails of preventing the progress of the disease (and such cases are in the very great majority) its further manifestations are milder and more evanescent in character than usual.

Several of the older men among the Germans, and all the French syphilographers, with the single exception of Julien, believing as they do that the initial lesion is to be regarded as the first symptom of syphilis, and that by the time of its development the whole organism is already affected by the disease, deny that its excision is possessed of any prophylactic virtue whatever.

Such is the statement of the case. The evidence as to facts is conflicting, the theoretical discussion of the problem is without definite results, and the question is to be regarded as yet unsettled. The only

*Read at the May Meeting of the Kentucky State Medical Society, 1893. For discussion see p. 76.

practical outcome of the discussion thus far has been to show that excision of the initial lesion is not followed by bad consequences when thoroughly done. Medical literature has been scant upon the subject. The opinion of Auspitz and his followers has not been substantiated by late syphilographers.

The auto-inoculability of the chancroidal virus and the non-auto-inoculability of the virus from the Hunterian chancre have left the conclusion in the mind of the profession that the former is truly a local and the latter a constitutional disease. The only question to be determined is, is the chancre the local effect of a contaminated constitution, or is it an initial lesion? If the non-auto-inoculability of virus from chancre is an established fact, then excision of chancre is not a justifiable operation.

The reasoning mind must admit that a period must elapse from the time of the exposure to systemic contamination. That time I do not think has been definitely established. If chancre is the primary lesion, as is entertained by some of the most eminent pathologists, then excision becomes a justifiable operation. Excision of cancer before the adjacent glands become involved is followed by the best results. Why not the excision of chancre?

So meager has been the literature on the subject that no definite time for excision has been prescribed, but if you will admit of the practicability of the procedure I will say that excision is practicable at any time before the adjacent lymphatics become involved, and I believe that the chancre is local till it breaks through the basement membrane. Then, and not until then, is the circulating fluid compromised and infected by its virus. If pathologists will establish the fact beyond question that chancre is the initial lesion, the profession could impress upon the laity the importance of early professional advice, and the patient would be spared months and probably years of bodily affliction and mental anxiety.

The moral effect of cauterization of chancre has been well demonstrated to the surgeon. The patient wants something done, and wants it done quickly. Every surgeon of experience has had it potently demonstrated to him the ill effects of cauterization, and the more conservative ones have abandoned this practice, though many still hold to it for its well-known moral effect on the patient. The operation of excision under cocaine is an easy and painless one, and if justifiable should receive more attention from the general practitioner.

SUPERIORITY OF COCAINE OVER OTHER MYDRIATICS IN IRITIS.*

BY P. RICHARD TAYLOR, M. D.

Professor of Materia Medica and Therapeutics in the Hospital College of Medicine, Medical Department of the Central University of Kentucky, member of the Jefferson County Medical Society, and of the Mitchell District Medical Society of Indiana, and of the Kentucky State Medical Society, etc.

Iritis is produced by traumatism of the globe, although it is commonly due to malaria, gout, syphilis, rheumatism, and other systemic diseases. When the cause is removed the treatment is simple. It is in those cases where it is difficult to remove that cocaine has its greatest advantage over the mydriatics ordinarily used.

We have learned to rely on atropine in all the forms of this disease, whether simple or complicated with cyclitis or conjunctivitis. The greatest care must be exercised in its use, or it will cause the most serious disorders, among which are conjunctivitis, increased tension, and atropine poisoning. The other favorite mydriatics, daturine, hyoscyamine, duboisine, atrosin, and homatropine are subject to similar objections, and they also cause systemic poisoning.

I offer cocaine to you as a substitute because it can be used an indefinite time without deleterious local or systemic effects. A few drops of a ten-per-cent solution of this mydriatic instilled into the conjunctival sac is rapidly absorbed, carried to the inflamed iris, paralyzes the ends of the motor oculi, stimulates the sympathetic nerves, and produces dilation of the pupil, at the same time paralyzing the terminal ends of the sensory nerves, and relieves pain and photophobia.

It also contracts the blood-vessels to such an extent as to render them almost bloodless, which will control the inflammation by arresting the escape of inflammatory material through the coats of the vessels.

In iritis, in order to get the best effects from cocaine it should be used in concentrated form and frequently applied, for it has a tendency to limit its own absorption by contracting the blood-vessels of the conjunctiva and rendering them almost bloodless. The more intense the inflammation the more concentrated should be the application. I use a twenty-five-per-cent aqueous solution or a salve of petrolatum one hundred parts and cocaine twenty-five parts. The latter I prefer because it remains much longer in the conjunctival sac than the aqueous solution.

*Read at the May meeting of the Kentucky State Medical Association, 1893. For discussion see p. 66.

CASE 1. January 13th: John M., aged thirty-five, put himself under my treatment. I found him suffering from rheumatic iritis in both eyes. In left eye the aqueous cloudy, iris a muddy color, pupil contracted and conjunctiva inflamed. In the right eye symptoms were not so severe, no clouding of the aqueous, iris a dingy color, pupil contracted, episcleral vessels around the sclero-corneal juncture congested, conjunctiva not inflamed. As an experiment I prescribed for the left eye three drams of petrolatum and forty grains of cocaine, to be applied every two hours. For the right eye I prescribed two grains of atropine and one half ounce of distilled water, to be dropped into the eye every three hours.

January 18th: Left eye was much improved, aqueous was clear, conjunctivitis not so severe. Right eye was worse, aqueous was cloudy, conjunctiva inflamed.

I ordered the salve stopped and the atropine to be instilled into each eye. January 24th the left eye had become worse, and the right eye was not improved. I then ordered the atropine solution stopped and the cocaine salve to be used in both eyes. January 30th both eyes were much improved; salve was continued until patient was dismissed February 17th, with neither synechia nor deleterious effects from the cocaine.

CASE 2. March 3d: Laura F., aged twenty-four, came to me with her left eye bandaged. Examination showed she had iridocyclitis, with increased tension. I prescribed the salve, three drams of petrolatum, two scruples of cocaine to be put into the eye every two hours. March 7th, tension of the globe normal, and the other symptoms improved. March 12th there was marked improvement, which continued uninterrupted till case was dismissed April 1st, the cocaine salve being the only local treatment.

CASE 3. March 31st, Carrie C., aged eleven, was brought to me with iritis in both eyes, not far advanced. I prescribed three drams of cocaine and one half ounce of distilled water to be instilled every two hours. April 7th, eyes much better, and continued to improve rapidly until she was dismissed well April 13th.

LOUISVILLE.

Reports of Societies.

KENTUCKY STATE MEDICAL SOCIETY.

Thirty-eighth Annual Meeting, Frankfort, Kentucky, May 10, 11, and 12, 1893.

THURSDAY, MAY 11TH—MORNING SESSION, CONTINUED.

Dr. F. M. Green, of Greendale, read a paper on Ergot in Labor and Abortion. [See p. 49.]

DISCUSSION.

Dr. Jenkins: It seems to me that in labor ergot is a medicine we can well do without. Artificial labor can be produced without ergot in a better physiological manner than with it. The drug often produces those threatening contractions dangerous to both child and mother. Hot water and thorough douching will accomplish all that ergot will do. If you have a patient who is exhausted and almost comatose from hemorrhage ergot will seldom act; the uterine fibers are too much exhausted for it to act upon them; if ergot acts at all in such a case, it takes too long a time. Hot water or heat applied there and thorough cleansing will much more rapidly produce the stimulation. As to ergot in puerperal eclampsia, I can not see that it has any office. In an experience of five cases of puerperal eclampsia the spasms were not stopped with the expulsion of the fetus; they continued until stopped by other means, so it would not seem that ergot is likely to accomplish any thing in such cases. It is more rational in cases of inertia or misposition of the child or hemorrhage or other exigencies demanding immediate attention to deliver by forceps. In hemorrhage ergot often causes the retention of a hard blood clot in the uterus to give subsequent trouble. In cases of inertia ergot is likely to injure both the child and the mother. The forceps extract rapidly and their action can be completely controlled. If version or any other obstetric operation is to be done, ergot will certainly interfere with it. Every city physician knows the great mischief done by midwives in the use of ergot during the first and second stages of labor. The intense contraction of the womb thus induced does often serious damage to mother and child. I am against the use of ergot either before or after confinement.

Dr. Swope: I heartily endorse a good many of Dr. Green's remarks; but I can not agree with the gentleman who has last spoken to the effect that ergot should be entirely abolished in obstetric practice. I think that ergot has its place and that the place will continue to be occupied. I do not believe in the indiscriminate use of ergot, and yet I feel certain of its good effects in many cases. The author speaks of the inability of the sys-

tem to properly take up the ergot at certain times; when this is the case we have a soluble preparation which may be given hypodermically, and which will certainly be absorbed.

Dr. Yager: I have found ergot useful in helping me out in many hard cases of labor. I am sorry to see so much discussion about doing away with that valuable drug. We older practitioners, at least, have used it so long, and have acquired such confidence in its usefulness in bringing about happy results in the termination of labor, that we would be loth to part with it. In cases of uterine inertia, the parts below being dilated, or dilat-able, nothing is better than a dose of quinine followed with ergot; the two together work hand in hand. I must contend that ergot is useful in proper cases. And I can not but think that its power for harm has been exaggerated. If any member of this Society has lost a case in midwifery in consequence of the administration of ergot I have never heard of it.

Dr. Green: I would add that I, like Dr. Yager, was raised under the old rule of the administration of ergot, and taught to use it on many occasions; and that I have abandoned it simply from the fact that we have other remedies which are better, and which can be at once resorted to, for instance, the forceps and pressure. I seldom use ergot now, where formerly I was taught to use it—in inertia, when I have reason to believe that the birth will take place in 15 or 20 minutes. The trend of my paper was to show that the use of ergot under these circumstances is dangerous, and that we have better means. The purpose of my paper was not to exclude or ignore ergot entirely, but to show that it might be supplanted by other and better measures—the forceps and pressure. Upon the subject of pressure I emphasize the treatment of Christella. In many cases it was the old method of obtaining uterine action in inertia.

EVENING SESSION.

Thursday, May 11, 1893, 8 P.M. Society called to order by the President.

Dr. P. Richard Taylor, of Louisville, read a paper on the Benefit of Cocaine in Iritis. [See p. 63.]

DISCUSSION.

Dr. Palmer: When coca was first introduced it was said that the natives of Peru were, by the mastication of the leaves of this wonderful plant, enabled to endure any amount of toil and deprivation, and that too without resulting depression. It was claimed of coca that it stood alone among all the stimulants as an agent not followed in its use by depression. I have had occasion, owing to the locality of my office, to use cocaine not a little in the eye, and have noted its mydriatic effect, as well as its local narcosis; but what I wished to speak of more particularly was the marked depression that follows the use of cocaine, either in those mucous surfaces that I am in the habit of treating, or as an internal agent, or even as used by limited

instillation into the conjunctiva. I think that the myth of a stimulant that shall not be followed by depression is a will-o'-the-wisp that will not be overtaken. While my experience in regard to the application of cocaine to the eye in the case of minor accidents is very small, yet I want to be put on record as saying that in a very large and daily use of cocaine in the upper air-passages in syphilitic lesion, and in the production of local anesthesia that is necessary in certain operative work that I do, I find frequently very pronounced depression following the application of the drug. I notice in Dr. Kraft-Ebing's recent work on sexual perversions that he reports several cases in which the sexual appetite is destroyed or very materially inhibited by the use of cocaine. I have had demonstration of this action of the drug, which I am convinced is not a specific or peculiar inhibition, but simply an evidence of its general depressing effects. While I do not think there is much danger of sudden death from cocaine (I have used it many hundred times without any thing more than practically unimportant, at least not dangerous, after-effects), I hold that it is not in any sense a stimulant that escapes the danger of subsequent depression; on the contrary it, far more than alcohol, ether, chloroform, or even the opiates, is liable to be followed by a profound but limited depression.

I have had under observation a number of cases of loss of sexual power by use of cocaine in the urethra, but in all cases these losses have been temporary and were simply, as I have said, specific phases of the general sedation that follows the stimulus of cocaine. I can not understand how there should have arisen and been generally accepted that wide-spread idea that there had been discovered here a plant more marvelous than the fabled lotus, and that it would stimulate and sustain through hours and days without any subsequent depression. I think, on the contrary, it illustrates the fact that there is no stimulant which can be used by physician or surgeon that will not be followed by an equal and perhaps a greater degree of depression.

Dr. R. B. Gilbert: Have you observed that any patients have acquired the cocaine habit?

Dr. Palmer: I think, with some of the recent writers on the subject, that the cocaine habit is one of the most difficult to develop. I have had but two instances, in a very large and free use of cocaine, in which the cocaine habit has been developed. Both patients used cocaine by sniffing it into the nose, and in both instances, when the cause of their depression and physical and almost mental obliquity was explained, they discontinued the use of the agent without any trouble whatever. I do not believe that cocaine will ever rank with opium or alcohol as a remedy to be feared from the danger of producing the enslaving habit. I think its power for harm here has been very much exaggerated. I have used it not a little myself from time to time after having had a nasal trouble, and found in its effects nothing of an agreeable nature. There is no euphasia produced, nothing more than a temporary cessation of pain, that would encourage one to cultivate it as one would cultivate the use of morphine or alcohol.

Dr. Taylor: I believe we are discussing cocaine in general use rather than in iritis. I do not believe any drug has been discovered which will stimulate without producing a corresponding depression. Mark you, the use to which I put the cocaine was for its depressing and not for its stimulating effects. I wanted the local depressing effects in order that we should not only dilate the pupil, but might lessen inflammatory action by means of the depressing influence of the drug. In using it in the eye we lessen absorption of cocaine into the deeper structures by the contraction of the blood-vessels which it induces in the conjunctiva, and by the constant application of cocaine and the constant contraction of these vessels without allowing the stimulus to come back, we can lessen the inflammatory process until we can remove the cause. We get our patient over this depressing effect gradually, gradually allowing him to come out from under the influence.

Dr. Palmer has told you that he got a decided depression from the ordinary dose in his genito-urinary practice. We know that the injection of cocaine in very small amounts into the urethra, or into the prepuce, scrotum, or testicle will cause an anesthetic condition and a general depression of the blood supply, and that when injected into the skin near the base of the penis will cause marked contraction of the vessels, not only in the penis, scrotum, and testicles, but will lower the temperature of these parts in a decided manner. The testicles will become completely insensible, and the same impression will be made on the patient's system that ablation of the testicle will make. The powerful depression, even to nausea, which occurs in these cases, and the general slimy or oozy sensation felt are reflex. The speaker also told you that in the other two cases, where the cocaine habit was established, he used the drug in the air-passages, and as a powder or as a snuff. The rhinologist and laryngologist, as a rule, do not use cocaine so recklessly or lavishly. If you want to anesthetize a certain structure in the nose do not snuff up the cocaine. This causes too wide a distribution for immediate local effect, and the drug will be absorbed into the general circulation and produce the systemic effect. If the cocaine be used in concentrated solution and applied directly on the structure the local anesthetization will be obtained without the general anesthetization, which must result from the absorption of a full dose into the general system, and the depressing effect will be avoided. We have three turbinated bodies in the nares, and we can make application to any of the three if we wish to remove it without affecting the sensation of the others; that is, we can simply limit the effect of the cocaine, and, as I said, by limiting its application we limit its absorption.

A paper on Cholera, by Dr. J. L. McCormack, of Bowling Green, was read by title.

Dr. A. W. Quinn, of Henderson, read a paper entitled A Case of Suppurative Peritonitis; Laparotomy; Recovery.

Dr. J. Morrison Ray, of Louisville, read a paper on Some Hereditary and Congenital Eye Diseases.

Dr. William Bailey, of Louisville, at the request of the State Board of Health, made some remarks on the recent endemic of typhoid fever in Louisville. He said: "For the last two or three months it has been observable in Louisville that there was an undue prevalence of typhoid fever in perhaps the best district of our city. Those who are familiar with the beautiful residence part of the city south of Broadway and extending east and west will understand what part of the city is included when I say that the fever has been prevalent from Preston Street to Eighth, about six by eight blocks, making 48 or 50 blocks in that territory to which the endemic was limited.

As a local officer of the State Board of Health my attention was called to this, and I began investigation some weeks ago to ascertain if possible where the cause was. We have had no undue prevalence of typhoid fever in any other part of the city. We always have it with us more or less. I began the search, if possible, to find something that was common to these people who are the subjects of typhoid fever, and to ascertain if possible why the disease prevailed. By inspection at the engineer's office I got a map of the sewerage of that part of the city and found nothing in that connection that would give me any information. In other words, I found that these cases prevailed on the streets where we have sewers, where we have none, where we have sewer connections with the houses, and where we have none. There was nothing in this relation that seemed to be affecting the people at all, so far as we were able to say, the sewerage in that part of the city being remarkably good.

Next I concluded to investigate the water supply of the city, and I found that almost universally Ohio River water was being used by that part of our people. If hydrant water is responsible for typhoid fever there, then typhoid fever ought to prevail wherever the water is used, but it is distributed equally likewise to many other parts of the city, and abundantly, and typhoid fever does not prevail to this extent; hence the hydrant water as a cause must be rejected.

Next, recognizing the probability of a milk supply as being the origin of the disease, I looked into this question, and had gone but a little way until it became very evident that the majority of the people sick were taking their supply from one dairy. This attracted my attention very soon in the investigation, and these facts then devel-

oped: That in this territory of 50 blocks there were 20,000 to 30,000 people. This dairy claims to deliver milk to over 200 families, at a large estimate 1,000 people. We have at least then 20,000 people in this same district that are taking milk from some other source. Upon the investigation I located in this territory in the last two months, say 54 cases of typhoid fever. Forty-four cases of these had been drinking milk from this one dairy, then delivering milk to 1,000, which is a large estimate for a dairy of 30 cows to supply. Then we have 44 cases out of a 1,000 people to whom this dairyman delivers milk, whereas we have only 10 out of the 20,000 where the milk from other dairies is used. This then was a very suspicious circumstance.

Then I took it upon myself to make an inspection of this dairy, and I must say that I found the cow-sheds, the house, the dairy, every thing apparently in the most admirable order, and recognizing that these lower animals are not the subject of typhoid fever, and could not transmit the specific cause of it in the milk as it comes from the cow, and recognizing that close relation existing between milk and water, I thought possibly that the water used for cleansing the cans was the source of the infection. I therefore had a bacteriological examination of the water supply made, and to complete the demonstration the bacillus which Dr. Vissman exhibited to-night at the Capital Hotel is from the water of the cistern on this dairy farm."

Supplementary to Dr. Bailey's remarks, Dr. William Vissman said: "I do not see that I can add any thing to Dr. Bailey's report, except that the bacilli found show the morphology exactly of the Eberth bacillus. This, as with numbers of other cases that might be cited, where a typhoid fever epidemic has raged in a locality, was traceable to water, and when this water was boiled or the water supply cut off the typhoid fever epidemic was cut off. I suppose that is evidence that the disease is caused by the Eberth bacilli; but we can not reproduce this disease in the lower animals with these bacilli.

DISCUSSION.

Dr. Palmer: I am proud of being one of the very earliest converts to the germ doctrine, not the theory, but the doctrine that germs are a source of disease production, but I am surprised that Dr. Bailey and Dr. Vissman, in presenting this exceedingly important local instance to the State profession, have not gone more elaborately into what we might call the clinical history of the case. The milkman claimed that about 700 people drank his milk, and he showed me to-day a list of 25 cases of typhoid fever in the

same neighborhood in people who had never taken milk from him; one of the cases being my niece, living three doors from my house. I was also told by Mr. J., in whose family there are two cases of typhoid fever, the family being supplied by milk from this dairy, that the two people in the family who have typhoid fever are the two members of the family that did not drink the milk. But, to offset that, I am told of a case of a family in which all drank the milk boiled except one lady, who would not drink it boiled, and she has typhoid fever. Now the milkman tells me that while the bacillus is found in the water of his cistern it was not found in the spring from which he waters his cows, and not of course in the milk; and further, that the typhoid fever had existed among his patrons three weeks before he could have used the cistern-water in washing the cans. The fact that a very large number of people, presumably susceptible to the disease, consumed this milk and have not been infected, and the fact that a very considerable number of cases prevail in the afflicted neighborhood that do not take milk from this particular milkman, and the fact that a large number of typhoid fever cases exist elsewhere in our city who do not take milk from any part of that section of the country where this dairy is located are all points that should call for a very broad, very fair-minded and exhaustive analysis of the question. I do not treat typhoid fever, but my partner has now the eighth case of typhoid fever in one house, and none of the family had milk from the dairyman in question. So that while the demonstration of the existence of this bacillus in the water wherewith this milkman washed his cans is very dramatic, it must not be taken as absolute and conclusive proof that we have found the unquestionable source of this epidemic, which, call it typhoid fever if you please, has had some very curious phases in the manner of its clinical behavior. I would ask Dr. Vissman if he does not think it would be a good plan for him to quietly collect a very considerable amount of cistern-water from the suburban cisterns and see what percentage of the bacillus of Eberth may be found in such water, rather than to confine the investigation to a single dairy.

Dr. Reynolds: I have been very greatly astonished to hear that people had typhoid fever who never drank the milk of the implicated milkman. I do not suppose that Dr. Bailey and Dr. Vissman have hinted that a case of typhoid fever arising from the Franklin County milkman's product could not be the means of distributing it to the neighborhood. The matter is entirely new to me. The question is whether Dr. Palmer means seriously to say that the people of Louisville who have the disease and did not drink of that milk offer any sort of illustrative proof to his mind that the milk is not infected.

Dr. Vissman: I made this investigation at the solicitation of the State Board of Health, through Dr. Bailey. I reported to the State Board that I found a bacillus that in all its morphological changes tallies exactly with the Eberth bacillus; and in my previous remarks I did say that I did not know whether the Eberth bacillus was the cause of the typhoid fever or

not, because I can not prove it; but these epidemics are traceable to the water supply frequently, and if when this water supply is cut off, the epidemic is cut off, that certainly is an evidence in favor of the bacillus being the cause of the fever.

Dr. Taylor: It seems to me that it is proof positive, or at any rate clinical evidence to the effect that the milk was contaminated; but it is a question whether these new cases arising in the neighborhood may not have come from the privy vaults, and these patients who did not take the milk from the Franklin County milkman may have taken water from wells and got typhoid fever in that way; and it is more than probable that that is the way it was propagated in the neighborhood.

Dr. J. N. McCormack There are two or three points that have been suggested by Dr. Bailey and Dr. Palmer that are very interesting. I do not suppose that Dr. Bailey claims by any means that this may be the only dairy selling milk in the infected area which may possibly be infected by typhoid fever. I do not think it has ever been claimed that any one man might have a monopoly of that kind of trade. You may recollect the story of the lawyer who said to the Irishman on the witness-stand, when he was identifying his ducks (he had sworn to them very positively), "I do not see how you could do that; I think I have ducks running in my yard just like them;" and the Irishman replied, "I have no doubt of that, they are not the only ducks I have lost." It has occurred to me possibly that there may be ducks in other milk sold in this same locality. Now it has been said there were a great many people using this particular milk who had not developed typhoid fever. We know how few people who are exposed to the large number of infectious diseases really develop the disease; a very small percentage of people exposed to cholera and who are exposed to a variety of diseases which are unquestionably infectious really develop the diseases; that would hardly be taken as an argument. Those of us who have given much attention to the pension records of this country know that a great many people came back from the war without being killed, particularly those of the Federal army; but I do not think that many of us would argue from that that bullets are not dangerous. Only a very small percentage of men that go into battle are killed or wounded, and I have no question that even with a thousand people drinking milk known to be contaminated with typhoid-fever poison only a small percentage of them would develop the disease. Many of them are immune positively to the typhoid-fever poison, and those not immune from a variety of causes might not develop the disease. In a few instances, as in the instance given by Dr. Palmer of the family where two members did not drink the milk and still got typhoid fever, they most probably have used milk in their coffee or in their tea not raised to a sufficient temperature to destroy the germs of the disease, and in that way they would have been exposed to poison, and if not immune would probably have developed the disease; but however we may view the matter, the fact that out of 54 cases in this immediate

locality that had the disease 44 of them were people who used this particular milk supply is a very suspicious circumstance, and warranted us at the meeting a few days since to ask the health officer of the city of Louisville to interdict that milk until free from suspicion, that is, to give the community the benefit of the doubt until further examination had demonstrated that the milk might be safely used.

Dr. Palmer: I suppose inferentially, from Dr. McCormack's remarks, that the reason why I am still alive is because I was in the Federal army. I need not say, what is only too well known, that I have nothing to do with typhoid fever practice; but I saw that the subject was going to record with the short statement of Dr. Bailey, and with the still shorter statement of Dr. Vissman, and that the whole thing was going to drop, and I thought somebody in the profession of Louisville, which is largely represented here, should stir up a little agitation. Having accomplished this to the extent of having stirred up, among others, my friend Dr. Reynolds, I feel that I have done all that I hoped to do, and I trust that I will be pardoned for coming out from the clean cut lines of surgery into the broad, evasive, and misty fields of practical medicine.

Dr. Bailey: I have never said that this milk was the cause of the typhoid fever, and I do not intend to do so—I am threatened with suit for libel. I want to say, moreover, that I do not believe all the cases of typhoid fever in Louisville have been produced by this milk. I do not know whether, as Dr. Vissman says, this germ is the essential cause or not. I have only presented you a few facts, the principal one being that in this territory of 20,000 people, 1,000 of them having milk from one source, 44 cases of typhoid fever were developed, while out of the other 19,000 taking milk from other sources, 10 cases have developed. I would simply submit it on that history, and ask you as intelligent men, would you be willing to use the milk of that dairy in your family? I asked that same question of the Society to which I presented the matter, and none replied. I don't believe Dr. Palmer would allow his children to drink the milk. This has been no personal matter with me at all, and my sympathies are largely with the implicated milkman. My sympathies are largely with this man because from the beginning of this discussion his trade was naturally lessened, until I think it was a work of supererogation to ask the health department to forbid the use of the milk. In one family, which took the precaution to boil the milk, a young lady did not like boiled milk, and drank it without boiling. She is now in bed with typhoid fever, while the rest did not contract the disease. There is no argument to be drawn from the case of those people who, it is stated, do not drink milk, for enough milk is used with coffee, tea, berries, etc., to cause the infection if germs are present in the milk, unless the subject is immune to the disease. I present these as facts, and have done so that you may appreciate this demonstration of the Eberth bacillus by Dr. Vissman, who has kindly done this work and done it well. There will be a contest on this matter, as there is another expert who, I understand, pro-

nounced negative results from this water; but I know the experiments of Dr. Vissman have fulfilled all the requirements of scientific accuracy; he took his sterilized media to the dairy farm and inoculated them with water directly from the cistern in less than a minute after it was drawn. The gentleman who makes the negative report does it upon water that was sent to him by the milkman. The milkman told me himself that he sent the water to the gentleman for examination. Now, have they complied, in getting their negative results with the requirements of scientific investigation? Does the examiner know where the water came from? I am not charging now that the milkman presented any other water, but is it proof that that is the water that has been examined? And, moreover, suppose they have examined it a hundred times, and find negative results, does it invalidate the positive demonstration?

FRIDAY, MAY 12, 1893.

The meeting was called to order at 9 o'clock, A. M.

Dr. J. A. Stucky, of Lexington, read a paper on the Naso-Pharynx in Measles and Scarlatina. [See p. 57.]

DISCUSSION.

Dr. J. G. Carpenter, Stanford: I am convinced from former experience that the naso-pharynx and the exanthemata have been most seriously neglected by the general practitioner, and that if due attention was given to a proper local treatment many complications following in the upper air-passages could be avoided. This subject has been discussed more than once in the American Rhinological Society, and we have tried to make it a point to impress upon the general practitioner the necessity of giving proper local treatment. I have had several cases in which there were characteristic local symptoms of scarlatina without eruption, with albuminous urine, that in from three to six weeks afterward presented the desquamation peculiar to scarlet fever. I know of no other subject that demands the careful consideration of the general practitioner more than the local treatment of the naso-pharynx in the exanthemata.

Dr. E. J. Yager, of Campbellsburg, read a paper on Paralysis Agitans.

The paper consisted of a report of two typical cases of the disease occurring in the author's practice. The patients were a mother and her son, who both developed the disease after middle life. The author detailed the incidents of the clinical history of these cases with great care, and showed how they accentuated the obscurity of the pathology and the inutility of treatment in this remarkable disease. The bibliography of the disease was also well presented, and the little advancement made in our knowledge of paralysis agitans since the time when Parkinson and Watson wrote was made apparent.

DISCUSSION.

Dr. T. B. Greenley, Orell: Paralysis agitans, in my experience, is of rare occurrence, for in nearly fifty years I have seen but thirteen cases; two of them I recollect very well, although they were not of near so grave a character as those described by Dr. Yager in his paper. The patients were both elderly men when the disease came on. The pathology is very obscure, but I regarded those two cases as due to alcoholism. Both were very fond of a dram. It was in old times, when it was customary for people to drink more than they do now; but they were getting pretty well advanced in life when the disease came on: it never disabled them from going around; they were always able to travel and take due proportions of food, and they enjoyed fairly good health. One, however, the younger of the two, had to be fed for many years; he was unable to feed himself, and he was considerably troubled with agitation of the head and contraction of the facial muscles; the other one was never troubled that way. This man, however, strange to say, walking along a railroad track one day had an apoplectic seizure and became unconscious for a few hours. They took him home; he recovered in due time from that; he was hemiplegic for a few months, but he mended sufficiently to be able to walk around again. He got even so that he could feed himself; the agitated condition of his hands was much relieved, and his speech was much improved. Altogether the apoplexy, notwithstanding its serious nature, in this case proved to be a remedy for the paralysis agitans. Both these patients lived to be more than seventy years of age.

Dr. Dudley S. Reynolds, of Louisville, read an essay on the Present Status of the Medical Profession in the United States.

On motion of Dr. George W. Beeler, of Clinton, that part of the report of the Nominating Committee that refers to the next place of meeting was reconsidered.

On motion the President, Secretary, and Treasurer of the Society were appointed a committee to consider this matter and to report.

The president elect, Dr. J. Q. A. Stewart, of Frankfort, was conducted to the chair by Dr. Brown and Dr. Lyman Beecher Todd.

Being presented by the retiring president, Dr. Stewart said:

I am overwhelmed with the honor you have conferred upon me. I am profoundly grateful to be selected to preside over a body of distinguished men, such men as compose the Kentucky State Medical Society; it is an honor to be sought by any doctor in the State of Kentucky. I feel grateful to you because I have not been very prominently before the Society except in my regular attendance upon it. There was nothing due to me so far as any papers or any matter that I have presented to the association. I thank you most gratefully, gentlemen. I also have to thank you for the kind rec-

ognition you have given to the work that ought to be prominent in the heart of every physician in the State of Kentucky. I feel that it is a compliment to me because of the fact that I am representing a matter that every doctor in the State ought to take seriously into consideration. The work in which I am peculiarly engaged is not fully recognized or understood by the physicians, men who ought to know all about it. I only want to present that fact to you that you may take into consideration one of the grandest works in the world, and I know if you gentlemen would take that matter into consideration the legislature would favor it fully and abundantly. I thank you, gentlemen, for your consideration, and for the honor you have conferred upon me.

Dr. T. B. Greenley, of Orel, read a paper on the Credulity of the Medical Profession. Discussed by Dr. Yager.

Dr. T. N. Willis, of Finchville, read a paper on the Physician as a Public Benefactor and Sanitarian. Discussed by Dr. Greenley.

Dr. O. H. Reynolds, of Frankfort, read a paper on Syphilis; Excision of Chancre in treatment. [See p. 61.]

DISCUSSION.

Dr. Greenley: For a long time it has been a matter of doubt as to whether or not excision of chancre would prevent the development of the disease in the system, and I should judge from observation that if we could see the chancre immediately and excise it, that in all probability we might prevent the further development of disease, but unfortunately we do not have a chance to see the sore until probably the system has become contaminated. Therefore in most cases I should think it would be useless to excise the chancre in order to prevent further trouble.

A paper on Insomnia, by Dr. Pope, of Louisville, was read by title.

The following resolution was offered by Dr. Lyman Beecher Todd, of Lexington:

Resolved, That the thanks of the Kentucky State Medical Society, now in its thirty-eight annual session, in the city of Frankfort, Kentucky, be tendered to the Rev. Dr. Blaynes for the prayer offered, and to the Hon. Ira Julian for the eloquent address of welcome delivered to this Society when it assembled here; to the citizens of Frankfort for the delightful reception they have given the Society, to the citizens and medical profession of Frankfort and Franklin County for the elegant and enjoyable banquet; to the very courteous and attentive Committee of Arrangements for ample and convenient provision for the reception of this Society; to the press for courtesies; to the various railroads for reduction of fares to members and their families attending these meetings; to the Hon. John W. Hendrick for his

eloquent address; to the hotels for their courtesy to us and for the reduction in their customary rates; to the chairman of the Local Committee of Arrangements for the efficiency and ability in which he has discharged his duties; to Dr. Stewart for his hospitality tendered the Society at the Feeble Minded Institution.

Motion seconded and unanimously carried.

Dr. Lyman Beecher Todd: I desire to offer a motion to the effect that the thanks of this Society be tendered to Dr. Archibald Dixon, our retiring president, for his courteous and impartial ruling in administering his office, and that the vote be taken rising.

Motion seconded and unanimously carried.

The Society then adjourned, Friday, May 12, 1893, at 11:40 A. M.

Reviews and Bibliography.

The Anatomy and Surgical Treatment of Hernia. By HENRY O. MARCY, A. M., M. D., LL. D., of Boston. With sixty-six full-page heliotype and lithographic plates, including eight colored plates from Bougery and thirty-seven illustrations in the text. 421 pp. New York: D. Appleton & Company. 1892.

Dr. Henry O. Marcy is regarded, not only in this country but also abroad, as an authority on the subject of hernia. A work fully setting forth only his own teachings in the operations for the cure of this so common and so important disease must be of great value, but in this he also presents the teachings of all the leading surgeons that at any time have contributed to existing knowledge of the subject. In his illustrations he has drawn from all sources, and has been especially careful in the selection of such as have adorned the monumental works of such geniuses as Cooper, Scarpa, Bougery, and others no less celebrated. What with the attractive colored plates, and with its many well executed cuts, its large, tasteful, and open type, its pleasing style and superior breeding, it constitutes an edition *de luxe*, and is unsurpassed by any thing in the medical book line that has appeared this side of the water.

D. T. S.

Elementary Physiology for Students. By ALFRED T. SCHOFIELD, M. D., M. R. C. S. Philadelphia: Lea Brothers & Co. 1892.

The fact of the number of "manuals" and quiz "compendes" which are every year issued shows well the demand that exists for them, and it takes no special amount of originality to construct one. This little work is published in a very attractive form, and the author has embodied in it much

more than is usually found in this class of works. The illustrations are good, and discretion has been used as to the choice of subjects for special elaboration. It is the opinion of the reviewer that a much more comprehensive idea of the subject can be had on the part of the student from the more thorough text-books than from a manual, though they serve a purpose when a special and hurried review is anticipated. For this purpose this little work is well adapted.

H. E. T.

The Disease of Inebriety from Alcohol, Opium, and other Narcotic Drugs: Its Etiology, Pathology, Treatment, and Medico-Legal Relations. Arranged and Compiled by the American Association for the Study and Cure of Inebriety. 400 pp. Price \$2.75. New York: E. B. Treat. 1893.

This book, though purporting to be a report, has in fact been worked up into a fairly consistent and well-proportioned treatise on the subject of inebriety. To one who does not feel the need of being appealed to "line upon line and precept upon precept" there is more of repetition than seems necessary for the full understanding of the lessons that Secretary Crothers would convey. He has culled from almost every possible source, either directly or indirectly, facts and opinions bearing on his subject, and arranged them in a very readable form. The principal trend of the work seems to be to prove that inebriety is a disease, and that this fact should be constantly kept in mind in the punishment of inebriates for violation of the laws.

D. T. S.

Lessons in Physical Diagnosis. By ALFRED L. LOOMIS, M.D., LL.D., Professor of the Practice of Medicine and Pathology in the University of the City of New York. Tenth edition, revised and enlarged. New York: William Wood & Company. 1893.

A review of this work, already so well known, is hardly necessary. There has been little new offered in the methods or results of physical diagnosis, but a work from the pen of this author is sufficient indorsement for it.

This edition has been enlarged, and is attractively bound. One new chapter on Clinical Microscopy has been added, and the sections on Physiological Action of the Heart and on the Examination of Urine have been rewritten, the latter being much more comprehensive than in the former editions. The illustrations, many of them, could be improved upon, but the new colored plates are well executed.

This work has much to commend it, and will prove itself valuable as a reference book as well as a text-book for students.

H. E. T.

Foreign Correspondence.

LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

A New Memorial to John Hunter ; A New Treatise on Drunkenness ; A Long Felt Want Supplied ; Dr. Schofield on the Treatment of Cholera ; Atropine in Cholera ; A Deputation to the Local Government Board ; Lady Medicals in a New Rôle ; A New Asylum, etc.

A special meeting has been held at St. George's Hospital for the purpose of considering the proposed memorial to John Hunter, who served five years as senior surgeon to the hospital, and died just a century since. It was resolved that the memorial consist of such a piece of sculptor's work as the funds at the disposal of the committee may enable them to procure.

Dr. George Wilson has published a treatise on drunkenness, as a practical outcome of a course of four lectures delivered by him last year to the students of the Edinburgh Free Church College. Dr. Wilson points out that the great questions that are pressing upon the public consideration are the cause and the cure of drunkenness, and it is in relation to these points that Dr. Wilson's book proves of most value. Dr. Wilson more than doubts the accuracy of Weismann's theory of heredity, and is strongly of opinion that Weismann failed to estimate the real importance of the environmental factor in development, by which hereditary vicious taints are perpetuated. The remedial policy advocated by Dr. Wilson is a recommendation of compulsory confinement of confirmed drunkards in restorative homes, under the control of a Supervising Board, and the introduction of the Gothenburg system in a form suitable to the conditions of life in the United Kingdom, together with stricter police regulations.

Sometime since the sum of £100,000 was left to establish a convalescent home in connection with certain of the London hospitals which were unprovided with such institutions of their own. Fifty acres have been purchased in a most healthy part of the county of Kent, and a series of buildings have been erected capable of accommodating one hundred and twenty patients, eighty men and forty women. During the past month the beds have been allotted, the London Hospital having the use of thirty; Guy's, St. Thomas', and Middlesex twenty each, and Westminster and St. Mary's fifteen each. The trustees, after paying all costs and expenses attending the erection and furnishing of the institution, have at their disposal an annual income from the endowment fund of about £3,500.

Dr. Schofield, in a lecture at the rooms of the National Health Society on the treatment of cholera, spoke of the presence of germs in the atmos-

phere everywhere except at a height of ten thousand feet and a yard below the virgin soil. He said the cholera germ had a period of incubation of from one to fifteen days, but the average period was from two to five days. He described cholera as a dirt disease. Infants in arms were always exempt from it, and it was rare under three years of age. One of the principal preventives and one of the points when a person had got the disease in determining whether he would die or live was the question of reserve strength. Dr. Schofield impressed upon his hearers the necessity of all within the range of the epidemic to keep up the best possible strength to be able to resist the disease.

The Home Secretary has appointed a committee to make special inquiries into the various manufactures which are said to be dangerous or unhealthy for the workers. The committee will carefully look into the conditions of work in lead, pottery, chemical works, and quarries.

Dr. Landor Brunton's paper upon the value of atropine in cholera, which he read at the recent meeting of the Royal Medical and Chirurgical Society, attracted much attention. Dr. Brunton said he first drew attention in 1873 to the great resemblance between the symptoms of cholera and those of muscarine poisoning, and furthermore to the fact that the symptoms of muscarine poisoning were removed by the subcutaneous injection of atropine. This led Dr. Brunton to conclude that good results might be hoped for in cases of cholera poisoning by the subcutaneous use of atropine. He had no opportunity of putting this idea to a practical test until a few months ago he had under his care a child who had recently come from Hamburg. The father of the patient died very shortly after admission to the hospital; the child was *in extremis* when first seen, but was revived by a subcutaneous injection of atropine. After a short period a severe relapse set in, but good results were obtained by a second injection, and the child recovered. Dr. Klein suggests that there are various forms of cholera, and thinks that in cases where cholera chiefly affects the circulation atropine will be of service, but less so in those cases where the intestine is chiefly affected.

A deputation of members of Parliament representing the port sanitary authorities have waited upon the president of the Local Government Board in order to urge the desirability of making an arrangement under which the treasury would contribute a substantial amount toward the cost of precautions undertaken at the instance of the Local Government Board against an outbreak of cholera. In reply the president said that it was obvious that from London down to the smallest port additional expense would be incurred. This department did not believe in quarantine. The Chancellor of the Exchequer had already made arrangements that there should be no additional expense cast upon local authorities in respect of visitation of medical officers of all ships entering a port. He thought the Government had largely met the case, especially in smaller ports where the customs would assist in the matter of visitation. With regard to the extra expense in reference to hospital isolation he could only say that he would consult

the treasury. Outside this aspect he could not see any legitimate demand for subvention.

The students of the London School of Medicine for Women at a recent fire acted the part of "fire women" with great credit. It appears that some thirty of the lady students were in the reading-room and museum of the institution when an outbreak of fire was noticed in an adjoining lumber-yard, and immediately, without the slightest confusion, they set to work as their regularly held fire drill had accustomed them to do. The hose was run out, ladders placed against walls, and the hydrants turned on. Some of them mounted to the roof, others taking their places on the ladders or boundary wall between the two establishments. During the progress of the fire they poured tons of water on the threatened buildings, as at one time great anxiety was felt for the safety of the Royal Free Hospital, and it was deemed necessary to move the patients. The officials of the Metropolitan Fire Brigade spoke highly of the action of the lady students, and said they materially assisted the firemen.

Provision for the insane makes increasing demands on the authorities of the metropolis. When the administrative County of London was formed in 1889 the London County Council became responsible for the care of no fewer than 10,104 pauper patients. At the beginning of the present year the number had increased by 730, while the accommodation within the county itself was sufficient for less than 8,000. To remedy this condition of things the County Council have proceeded with the erection of a new asylum, which will accomodate 2,000 persons. In spite of this addition the chairman of the Asylums Committee says that the County Council will shortly be compelled to erect yet another large building for the treatment of the insane.

The lecture of Dr. Thorne Thorne, principal medical officer of the Local Government Board, on Cholera Prospects and Prevention, delivered to the technical lecturers and the members of the National Health Society, was largely attended and most attentively followed.

LONDON, June, 1893.

BICARBONATE OF SODA AND DIGESTION.—Linossier and Lemoine, in a communication to the French Academy of Medicine, conclude that bicarbonate of soda in all doses excites gastric secretion. According to their observations, the dose which produces the most powerful effect is one of five grams given an hour before a meal. The action is prolonged beyond the day of administration, an increased secretion being kept up. It is essentially to be used in cases of insufficient gastric secretion, and ought to be given some time before a meal. In cases of excess of acidity it only acts as a palliative, and there is a risk of its aggravating the condition. They suppose that the administration of hydrochloric acid is of more service in diminishing the excess of secretion, just in the same way that alcohol retards alcoholic fermentation, or lactic acid lactic fermentation.

Abstracts and Selections.

MEAT-EATING AND BAD TEMPER.—Mrs. Ernest Hart, who accompanied her husband in his recent trip around the world, appears to come to the conclusion that meat-eating is bad for the temper. In the Hospital she says that in no country is home rendered so unhappy and life made so miserable by the ill-temper of those who are obliged to live together as in England. If we compare domestic life and manners in England with those of other countries where meat does not form such an integral article of diet, a notable improvement will be remarked. In less meat-eating France, urbanity is the rule of the home; in fish and rice-eating Japan, harsh words are unknown, and an exquisite politeness to one another prevails even among the children who play together in the streets. In Japan I never heard rude, angry words spoken by any but Englishmen. I am strongly of opinion that the ill-temper of the English is caused in a great measure by a too abundant meat dietary combined with a sedentary life. The half-oxidized products of albumen circulating in the blood produce both mental and moral disturbances. The healthful thing to do is to lead an active and unselfish life, on a moderate diet, sufficient to maintain strength and not increase weight.—*Boston Medical and Surgical Journal*.

LEGAL EFFECT OF ACCEPTING AN AMOUNT LESS THAN BILL RENDERED.—It is a general principle of the law that where a demand is liquidated or fixed, and the liability of the debtor is not in good faith disputed, the acceptance of a less sum than is the creditor's due will not, of itself, discharge the debt, even if a receipt in full is given. In such case the element of a consideration is lacking, and the obligation of the debtor to pay the entire debt is not satisfied. Unfortunately, however, this rule is denied application to bills rendered for medical services, according to a decision of the Court of Appeals of New York in *Fuller v. Kemp*. Here a physician made out a bill for \$670 for medical services, in settlement of which a check for \$400 was sent him, and stated to be in full satisfaction. This was retained, credited on account, and a bill for the balance rendered. The person charged thereupon again wrote the physician, calling his attention to the express condition upon which he had forwarded the check, and that it was sent as payment in full satisfaction of the latter's claim for professional services to date; that he did not recognize his right to retain the amount so offered and repudiate the condition of the offer; and requested him either to keep the money upon the condition named, or return it to him by first mail. To this letter the physician made no reply, but kept the amount of the check, and after the expiration of nearly a year brought action for the

recovery of \$270, the balance of his account after applying the \$400 received. Under such circumstances the court said that no further recovery could be had.—*Journal of the American Medical Association.*

A NEW CANCER CURE.—The following is a specimen of the kind of rubbish which is published by the lay press, and from which the public derive much of their curious medical beliefs: "A new way of combating cancer is the discovery of a German physician named Felheisen. Perceiving an affinity between cancer and erysipelas he injected the virus of the latter into dogs which had been previously inoculated with cancer, with the result of the disappearance of the latter. It is on the principle pursued by Dr. Felheisen in his canine experiments that the physicians in the great cancer hospitals, both of this country and Europe, are now proceeding to rob cancer entirely of its sting. When the disease makes its appearance they inject a brood of erysipelas 'cultures,' which they have raised artificially in a medium of gelatine or beef-tea, into the blood of the patient. The erysipelas cultures fight the cancer microbes in the blood, and do not cease until they have exterminated them. The cultures then are expelled from, or of themselves leave the system when they have done the work, and the patient is cured." We may before long have cancer institutes where people are cured by wholesale with hypodermic injections.—*Boston Med. and Surg. Journal.*

TREATMENT OF ENLARGED PROSTATE.—The following is the verbatim answer to the above question by a female applicant for admission to one of our State medical societies: "The treatment of enlarged prostate is rest in bed, if very large. Then strapping. (In old persons are liable to sudden passage of pure blood from ureter, no cause known, collapse and death within thirty-six hours.) If it can not be reduced by this means, then suspensory bandage must be worn constantly to take off all tension and liability to acute inflammation."—*Ibid.*

HARDWAR FAIR.—This fair, which is partly religious and partly mercantile, is yearly held in the north of India, and attracts thousands of natives, crowded in unhealthy surroundings. Last year it was the starting-point of the epidemic of cholera which invaded Europe. This year the fair was of normal size, having been attended by from seventy to eighty thousand pilgrims; but, largely owing to the precautionary measures adopted by the government, no case of cholera occurred.—*Ibid.*

AN exchange publishes the following bill-head of a doctor in Kansas: "A prompt settlement of this bill is requested. If bills are paid monthly a discount of ten per cent is allowed. Bills not paid monthly will be passed to my attorney for collection. If you pay your doctor promptly, he will attend you promptly, night or day, rain or shine; while your slow neighbor suffers and waits, as he made the doctor wait, and while he is waiting the angels gather him in."

THE AMERICAN PRACTITIONER AND NEWS.

"NEC TENUI PENNÂ."

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No. 2.

D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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BROMOFORM IN PERTUSSIS.

This remedy has been the subject of considerable comment in medical writings of late, and the consensus of opinion is that it is a valuable remedy in this troublesome disease.

Dr. C. W. Earle contributes an interesting article in the Chicago Medical Recorder on the "Étiology of Pertussis and its Treatment with Bromoform." He reviews the opinions of foreign investigators, all of whom agree in the main that this disease is infectious and transmissible, "and that it is probably transmissible by virtue of a local influence which acts only upon certain limited portions of the mucous membrane of the respiratory tract and proceeds from the expulsion or exhalation, and of the diffusion of a fixed principle upon different areas.

"Letzerich has discovered in the sputum of patients suffering with pertussis a peculiar germ—small, elliptical, reddish-brown spores, some of which are budding. These vegetable parasites are particularly numerous during the convulsive stage. They cover the epiglottis, larynx, and trachea, and sometimes invade the alveoli and produce catarrhal inflammation. Sputum from a pertussic patient will, in six to eight days, produce the peculiar cough."

Dr. Earle advises that in order to learn the efficacy of this or any other drug it is necessary to ascertain the number of paroxysms in twelve or twenty-four hours—Trousseau stating that forty paroxysms in twenty-four hours made the disease a serious one.

The drug he describes as a light colored, volatile, rather pungent smelling substance. It is made by the action of alcohol on bromine in the

presence of some alkali. It should be given in doses from one half drop to a child one year of age to two or three drops to children of five or six, suspended in some mucilaginous vehicle. Its action appears to be somewhat similar to belladonna. It was tried by the author in fifty cases, and without exception the number of paroxysms were diminished very greatly within three days after the commencement of the bromoform treatment. A little dizziness may be experienced from an excessive dose. He mentions the reports which have come under his notice by Dr. Fisher (Medical Record) reporting 51 cases, believing it to be the best known remedy when properly applied, Dr. Burton Fanning (The Practitioner) in 30 cases with uniformly gratifying results, using the mixture in the following form:

| | |
|--------------------------|----------|
| R. Bromoform..... | ℥i; |
| Pulv. tragacanth co..... | ℥ ss; |
| Syr. simp..... | ℥ ss; |
| Aq. ad..... | ℥ ss. M. |

Dr. T. J. Duncand reports 5 cases, with a diminution in number and in severity of the paroxysms.

Stepp, of Nuremburg, who first advocated its use, treated 100 cases without a single instance of failure.

Dr. Newman treated satisfactorily 25 cases.

Dr. Schippers, in his polyclinic and private practice, treated 250 cases, with good results.

Ullman, after a study on the subject, concludes that it does no more good than other remedies long used.

Dr. Nauwelaers reports a fatal case poisoned by a solution of seven drams to one fourth of bromoform dissolved in an equal amount of alcohol, of which two drops were given.

Kerley (Archives of Pediatrics) gives the latest report of 3 cases in which the remedy was administered early, and under the treatment the disease lasted four weeks, at the end of which time they were practically well.

Dr. Earle, in conclusion, gives the following formula for an emulsion:

| | |
|------------------------------|-------------------|
| R. Bromoform (Merck's) | gtt. viii; |
| Tr. opii camph..... | ℥ i; |
| Syr. acaciæ..... | ℥ ss; |
| Aq. anisi | } āā qs. ad |
| Aq. laurocerasii } | |
| | ℥ i. |

M. Shake well. S. From one half to one teaspoonful four times a day to a child one year old.

T.

THE STATE SOCIETY.

In this issue of the American Practitioner and News is published the last installment of the transactions of the State Society for the year 1893. These transactions represent the minutes of the Society, and the discussions upon the papers read, fourteen of which appear in full in this and the four preceding issues. As many more have, by the kindness of their authors, been placed at our disposal, and will be published in subsequent issues as we find room for them.

These papers and accompanying discussions have made large demands upon our space, and will make the coming transactions a fat volume.

The matter for this is now in hand for publication, and will be issued without delay, if the authors who read papers and did not hand them in will at once do so.

The editors herewith return thanks to the Fellows who so promptly placed their papers in our hands. The journal is the organ of the State Society, and the editors and publishers will spare neither labor nor cost to make it the worthy exponent of medicine as taught, practiced, and discussed, in the historic State of Kentucky.

EXTIRPATION OF A UTERUS AND FALLOPIAN TUBE FROM A HERNIA IN A MAN.—Bœckel (*Ann. de Gynec. et d'Obstet. ; Med. Chron.*, August, 1892) communicated an account of this case to the Academie de Medecine on April 19th. A young man, twenty years of age, consulted him on account of a congenital hernia which was causing pain. On performing the operation for radical cure, the operator found the sac empty, but its posterior wall inclosed a triangular body, covered by peritoneum, which was at first taken for an intestinal diverticulum; but the inguinal canal was empty, and the organ in question had no connection with the alimentary canal. Pressure made on the abdomen below the ring caused a pearly-white oval body to present at the external inguinal aperture. Parallel to this and just above it was attached a fimbriated cystic body, which could be nothing but a fallopian tube. These organs were removed *en masse*, and the operation was successfully completed. The parts removed consisted of three portions. There was first a two-horned womb, with a cavity lined by mucous membrane and ciliated epithelium. Secondly, there were a tube and a testicle with epididymis and vas deferens. Thirdly, there was a broad ligament connecting and inclosing these two organs.—*New York Medical Journal*.

Notes and Queries.

THE DOCTOR A GENTLEMAN.—Dr. T. B. Greenley, in the *American Practitioner and News*, has written a little essay on Why and How the Doctor Should Be a Gentleman, and by a gentleman he does not mean that special class technically so-called in monarchical countries, but a gentleman in the American sense, as Emerson has defined it. He means a person who is always considerate of others, who is courteous, kindly, and sincere. Dr. Greenley rightly says that there is much unnecessary hard feeling, ungenerous criticism, petty quarreling, and that there are many childish enmities and jealousies among medical men. Their work is made the harder thereby, their life less pleasant, their opportunities for mutual help restricted. In a town with a dozen physicians note the number who speak cordially to each other or of each other. They are as rare as righteous men in Sodom. Strange to say, each one has an excellent reason for his dislikes. Dr. A is inclined to advertise, Dr. B took a case away from him, Dr. C uttered some slanderous remarks about his way of treating a certain case of diphtheria, Dr. D is ignorant and plainly incompetent, and Dr. E is young and thinks he knows more than the rest already. So the comments run, and with each word another character dies.

But the true gentleman remembers that he himself, as well as all his brother men, are imperfect beings. There may be an excuse for the ill-natured remark or the ungenerous conduct. Perhaps the story was false. At any rate, a generous and kindly attitude toward the brother would be better in the end, for it would make him ashamed of himself.

If physicians only knew how much more they could gain by being tolerant rather than critical, courteous and friendly rather than distrustful, they would make some mighty efforts toward becoming always and everywhere gentlemen.—*New York Medical Record.*

AMERICAN SURGICAL ASSOCIATION.—At the recent meeting of the American Surgical Association the following were elected as the officers for the ensuing year: President, Dr. J. Ewing Mears, of Philadelphia; first Vice-President, Dr. Roswell Park, of Buffalo; second Vice-President, Dr. Lewis S. Pilcher, of Brooklyn; Secretary, Dr. J. R. Weist, of Richmond, Ind.; Treasurer, Dr. John B. Roberts, of Philadelphia; Recorder, Dr. DeForest Willard, of Philadelphia; Member of Council, Dr. J. Collins Warren, of Boston; Chairman of Committee of Arrangements, Dr. L. McLane Tiffany, Baltimore. The following were elected to membership: Drs. H. L. Burrell, of Boston; Perry H. Millard, of St. Paul; Albert B. Miles, of New Orleans; Samuel J. Mixter, of Boston; John W. Elliott, of Boston; John Parmenter, of Buffalo; J. McF. Gaston, of Atlanta. To honorary membership, Prof. Carl Gussenbauer, of Prague.

PAN-AMERICAN MEDICAL CONGRESS: SECTION ON GYNECOLOGY AND ABDOMINAL SURGERY.—All members of the medical profession are cordially invited to attend the meetings of this section to be held in Washington September 5th, 6th, 7th, and 8th. The sessions promise to be exceptionally interesting, many valuable papers having been contributed. Those who may wish to read papers before this section, and who have not yet sent in their titles and skeleton abstracts, are requested to do so at once.

Papers have already been contributed by the following distinguished gentlemen from the United States and Canada: Drs. T. Johnson Alloway, Montreal, Can.; A. W. Abbott, Minneapolis, Minn.; J. M. Baldy, Philadelphia, Pa.; H. J. Boldt, New York City; Augustus P. Clarke, Cambridge, Mass.; Ernest W. Cushing, Boston, Mass.; Andrew F. Currier, New York City; L. H. Dunning, Indianapolis, Ind.; Geo. R. Deane, Spartansburg, S. C.; W. E. B. Davis, Birmingham, Ala.; Joseph Eastman, Indianapolis, Ind.; Geo. M. Edebohls, New York City; De Saussure Ford, Augusta, Ga.; William Gardner, Montreal, Can.; T. H. Hawkins, Denver, Col.; John R. Haynes, Los Angeles, Cal.; Edw. W. Jenks, Detroit, Mich.; Jos. Taber Johnson, Washington, D. C.; Howard A. Kelly, Baltimore, Md.; Florian Krug, New York City; G. Betton Massey, Philadelphia, Pa.; Lewis S. McMurtry, Louisville, Ky.; R. B. Maury, Memphis, Tenn.; Wm. F. Myers, Ft. Wayne, Ind.; E. E. Montgomery, Philadelphia, Pa.; Robert T. Morris, New York City; Chas. P. Noble, Philadelphia, Pa.; Jos. Price, Philadelphia, Pa.; Geo. H. Rohe, Baltimore, Md.; Jas. F. W. Ross, Toronto, Can.; Chas. A. L. Reed, Cincinnati, O.; I. S. Stone, Washington, D. C.; R. Stansbury Sutton, Pittsburgh, Pa.; T. Algernon Temple, Toronto, Can.; A. Vander Veer, Albany, N. Y.; W. B. Ward, Topeka, Kan.

BROOKS H. WELLS,

71 W. 45th Street, N. Y. City, English-Speaking Secretary.

To the Editors of the American Practitioner and News:

ERRATUM.—In the report of the discussion of Dr. McMurtry's paper read at the recent meeting of the Kentucky State Medical Society, as it appears in the columns of your journal of the issue of July 15th, I am misquoted, and desire a correction. On page 33 I am made to say, "I believe that some of these minor operations have done more for the relief of suffering and the saving of life than any of the major operations, such as the removal of tubes, ovaries, ovarian cysts, and other tumors which occur in this region."

This is so far from the truth, so far from what I believe, and so far from the thought I endeavored to convey, that I have considered a correction of this paragraph imperative. The thought that I wished to impress in that discussion was, that many of the minor gynecological operations had done much for the relief of suffering and the saving of life; that all good accomplished in the gynecological field could not be justly claimed for the major operations. If you will make this correction in your next issue and set me right before the readers of your excellent journal I will feel greatly obliged.

JOHN G. CECIL.

THE AMERICAN PRACTITIONER AND NEWS

"*NEC TENUI PENNÂ.*"

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No. 3.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

THE AMERICAN DISEASE.*

BY J. W. IRWIN, M. D.

The subject I have chosen for this essay is wide in its application, and if I should attempt to elucidate its various forms I would occupy more time than is usually allotted to the members of this Society. I shall therefore pass in review briefly some of the features of what I believe is justly termed "The American Disease," and leave for you the more tedious task of filling in the gaps, as your keener sense of thought may perceive.

Those of you who anticipate the description of some new malady by its morbid anatomy will be disappointed to learn that the eye of the necroscopist has not penetrated its mysteries, nor the microscope revealed the insidious germ that numbers its victims by the thousands. We study its ravages only, and reach conclusions which to the observant student must cause the most serious thought. For we can not expect that mental and physical endurance in the offspring of such parents will rise above that of their ancestors. This insidious germ has escaped the vigilance of sanitarians, whose mission it is to prevent disease by exterminating its cause. "Man that is born of a woman is of few days and full of trouble." In these words will be found the key which unlocks the mystery of this insidious malady. In the great struggle for the survival of the fittest, we see in the marts of commerce, in the learned professions, and among artisans and men of every calling the

*Read before the Louisville Clinical Society, June 13, 1893. For discussion see p. 103.

greed of wealth. Not content with food and shelter and protection against the infirmities of old age, men wreck and ruin their frames; all drink from the same fountain, the waters of which contain a slow but sure poison, bringing suffering and premature death to those who quench their thirst in its deceptive waters.

A patient, the subject of this malady, applies for medical advice. He has passed the age of forty-five years; he may be younger, but he looks much older. His shoulders are stooped, and as he walks he seems laden with care. His brow is wrinkled, and his face wears the expression of anxiety. He is restless and can hardly wait for your opinion. Scarcely have you begun to inquire into his physical condition when you are met with the query, "Doctor, what is the matter with me?" Or, if he should be a man of observation, you will often receive his opinion in advance, as for instance, "I know my stomach or my liver is at fault." You can often see, as the patient enters the consultation room, in the restless eye and anxious tread that he has received the contagious infection, and the disease of wishing to be foremost in the ranks of wealth is for the time his most eager ambition. He has not yet learned that the increase of wealth beyond that which provides food and shelter and a competency against old age increases his responsibilities and makes the burden of his cares much greater, and the wear and tear of his nervous system to correspond.

We next observe this patient as he prepares for the business of the day, and we find that he breakfasts on roasted beefsteak, ham, eggs, and perhaps a slice of bacon. Hot rolls or biscuits and coffee complete the meal. As he bolts these viands the morning newspaper lies before him. His eye shifts from one column to another. The market reports of various nations are quickly in review. He next observes the pen picture of a tragedy or a prize fight which occurred a few hours before in Egypt, Germany, San Francisco, or New York. While the eye is thus engaged the mind is silently engrossed with the cares of business which the day is sure to bring. Perhaps some bill has fallen due, and provision is not at hand with which to satisfy his banker. Again, the price of groceries may have changed a fraction of a cent, or some debtor has assigned, of course always for the benefit of his creditors. These and often graver thoughts share the powers of the nervous system, while the increased process of repair and destruction are going on.

Breakfast is over, and the work of the day begins. One care crowds in upon another, and he finds himself stimulated by the anxieties of the

moment. The nervous system has reached the highest state of tension, and this condition lasts until time for lunch arrives. Refreshments are taken with the same rapidity as in the morning, and his work is resumed. Evening comes, and he goes to his house tired, careworn, and hungry. The evening meal is freely partaken of, and a business chat or a business meeting or plans for the next day are indulged in—amusements seldom intervene—and then to bed he goes. The mind is still at work. Some new idea or old one keeps it in motion, and he tosses about on his downy pillow until “tired nature seeks repose in balmy sleep.” He is indeed fortunate who has not to call to his aid some form of hypnotic by which he may for a short time seek oblivion in sleep. Perhaps dreams disturb his slumbers, and he awakes to learn that his stomach is not a good machine. He finds digestion slow, and attended with much discomfort. The morning comes to find him partially refreshed by the night’s repose, and he is ready to resume the work of another day.

Thus engrossed with the affairs of business and often personal cares he goes on and on for years. His summer holiday in the mountains or by the sea is often not a holiday at all. The mind never rests from business. So well is this matter understood by the wide-awake railroad official that, while in transit from place to place, he receives the account of the day’s doings in the commercial world at the way stations. Each palace car is provided with clerks and accommodations by which the busy man can conduct any sort of business as the train speeds along at the rate of fifty or sixty miles an hour.

Sooner or later this good business man finds that his health is failing; but he seldom stops to consider the cause. Not infrequently his infirmity is ascribed to malaria or heart-failure, and, after a few unsuccessful attempts to regain his wonted vigor, the love or the anger of the Gods may be accused as the cause of all his troubles. I have not heard of any one having the new disease which is said to be prevailing in London, and believed to be contagious; I allude to pancreatitis. As to whether the germs of this new disease have reached America or not our vigilant quarantine officials are silent on the point. This patient has gone on in search of health, and at last arrived at the conclusion that when he becomes young again he will obey nature’s laws. But he does not grow young. Very soon a surprise comes to his friends; some of the prevailing troubles have prematurely caused him to pay nature’s debt, and his place in the Stock Exchange is vacant.

We have the history of this patient, and we will now proceed to examine the internal organs. We find his heart is weak and his stomach has gone wrong. The liver has been taking a rest, and while failing to do its work, although frequently urged by the use of some vaunted cholagogue, it has become enlarged; or, on the other hand, by way of resentment to its keeper, it has become atrophied. The kidneys are not in a proper state of health. The waters of numerous mineral springs have been tried in vain. The brain has become quite sluggish, and memory has been playing vagaries with the patient. The spinal cord has gone wrong, and the reflexes are out of order. Parts of the body are cold, clammy, and almost lifeless. Those faculties which men most revere have become enfeebled, and no longer do their owner's bidding. Apprehension that he may soon have to leave the scene of labor, as evinced by failing manhood, is his chief companion.

Miserable man! He has become the patron of eminent specialists, and all have found dreadful disease; but a slight difference of opinion of his numerous advisers has caused him to seek further, and no doubt hope for speedy relief. The brain, nerves, muscles, and every internal organ suffer at every bearing. This, then, is a brief, imperfect picture of the American disease, the germ of which may be the Almighty Dollar.

Can we prognosticate for this patient, that he will regain his health? No; it is too late; the case is not a recent one, it is chronic; the germs of his trouble have been at work for years. The best we can do for him is to nurse his failing powers for a short time. We will prescribe advice only, as medicines can not cure him.

LOUISVILLE.

ORIGINAL STUDIES IN PHYSIOLOGY.

BY J. D. O'BRIEN, M. D.

SECTION I. THREE DISTINCT PRESSURES OR FORCES ESSENTIAL TO LIFE, RHYTHMIC AND CO-ORDINATE, YET NOT SYNCHRONOUS. We announce first that pressure is a potent force, assisting chemical changes, vital processes, molecular and morphologic transformations, and to properly appreciate its potentiality in the physiological actions, which we shall presently describe, we should first consider its effects in

cases which come under our common observation; and noting these carefully we shall proceed to unravel processes more obscure and yet more important, thus enabling us still further to interpret many complex and intricate phenomena exhibited in vital actions. The solution of chemical substances in water is much increased by pressure. Rain-water charged with carbonic acid, under much pressure under ground, forms a bicarbonate with lime-rock, dissolves it, and when the pressure is removed by its exit into caves the lime crystallizes into all those forms of beauty that adorn the cavern walls. Upon its exit into deep wells the solvent power of water is impaired, and the lime encrusts the goblet or kettle containing water, often obstructing the spout of the kettle. Most mineral waters acquire their properties by the solution of mineral elements by water percolating through their beds under a strong water pressure, and these waters, as soon as the pressure is relieved by their exit into wells or springs, begin to give up these solutions and to lose their strength and medical efficacy, because their solvent powers are increased by pressure and diminished by its withdrawal.

Pharmacy calls in the aid of pressure to increase the solvent power of water and alcohol in extracting the properties of medicinal plants, and commercial extracts needed in the arts are collected by aid of the same potent factor, pressure. In culinary art Papin's digester extracts under a high pressure the nutritive properties of bones not otherwise soluble. It is probable that rubber is vulcanized in the closed cylinder by pressure as much as by increased heat. The patent tanning machine opens the pores of the hide by a partial vacuum, and then tannin in solution is injected into the cylinder under immense pressure, and tannate of gelatin is rapidly formed, and the wonderful compound, leather, is made in days instead of months, as when potent pressure is not applied. The fluidity of the body (in amount three fourths of it) is preserved from the gaseous condition only by atmospheric pressure, as water boils in vacuo at about 76° , or 24° below the normal temperature thereof. The results of cupping, wet or dry, depend upon the abstraction of atmospheric pressure, and fluids seek to assume the gaseous condition when the pressure is lessened, forcing the blood out of lancet wounds, congesting skin and tissue, extravasating them with blood, and condensing the cooler glass with watery exhalations. This outward pressure is a potent factor in form and figure, and depends upon the atmospheric force of about fifteen pounds to the inch. But life

has vital forces or powers, and we propose now to speak of three grand mechanical powers, and these forces we shall also denominate pressure, having, like the atmospheric pressure, a numerical equivalent, which indicates their power.

Thoracic pressure and cardiac pressure have been long studied. I announce a third, the diaphragmatic pressure, a force originating by action of the diaphragm; a force not heretofore entirely unrecognized, but whose great agency is scarcely suspected. This has heretofore been announced by me, January 3 and February 28, 1891, in the St. Louis Medical Review, but it has been received with such indifference and incredulity as was Harvey's discovery of the circulation of the blood. No one has dared yet to attack my conclusions, and now, after two years of silence, I again put forward the claim that this power is as demonstrable as cardiac force or pulmonary force, and that its proper recognition is as necessary as either.

After over twenty-five years' study of this subject I demand its investigation by the profession. If I am right, it is criminal in the profession to longer ignore a subject as important as any thing submitted to them in this century. "Strike, but hear." "The world moves still," said Galileo *sub voce* when forced to recant. Then I announce diaphragmatic pressure as a rhythmic force, running up to 25 pounds in full inspiration, falling down to 16 pounds at the completion of the expiratory act; that this force of 25 pounds during contraction, increased and directed by the contraction of abdominal muscles acting therewith, accomplishes micturition and defecation, and when these forces are especially exerted, as in parturition, this force is vastly increased. Its violent spasmodic action occasionally rends the visceral walls in the various forms of hernia, the compressed viscera sometimes rending the diaphragm itself. These occasional normal and abnormal actions of the diaphragm have been observed by the profession, but it is with the normal (20 to the minute) work of the diaphragm that I have to do in this paper. This rhythmic force is essential to nutrition, and its normal power can not be impaired without a retrograde action in all nutritive and restorative processes, and some pathological changes in organs essential to life and health.

Cardiac action was studied by the aid of the hemadynamometer by Pouisselle, Volkmann, and others, and results tabulated as a cardiac force of $4\frac{1}{4}$ pounds, but these ingenious observers neglected to note that the heart was situated in a closed cavity and not supported by atmospheric

air, and as the registering tube of mercury was exposed to the air, and subjected to a pressure of 15 pounds, this number must be added to $4\frac{1}{4}$ pounds, and we assume that the corrected measure of cardiac force is about 19 pounds, and not $4\frac{1}{4}$ pounds. Now the heart projects its blood by the left ventricle into all the parts of the body, completing its circulation through arterioles, capillaries, and venous system in about one minute. We place thoracic pressure then at its maximum in expiration (when the thorax descends and the relaxed diaphragm is thrust up by viscera which are forced back by abdominal muscles) at about 16 pounds, terminating when the air is expired. Now the residual air begins to expand, as the thorax is elevated and enlarged; as the diaphragm contracts, the pressure falls to 7 pounds, and the outer air is forced in, forming inspiration, ceasing when thoracic pressure rises to 15 pounds. The heart is now beating always at about 60 to the minute, three times to one of thoracic pressure, and its force is 19 pounds.

Were the diaphragmatic pressure constant at 25 pounds, arterial blood, even at a corrected pressure of 19 pounds, could not possibly enter the abdominal cavity and supply the organs of digestion. As soon as the pressure diminishes, as the diaphragm relaxes and is forced upward, and the visceral mass, with its mixed solids, fluids, and gases, occupies a larger space, the pressure begins to descend, and as soon as it falls below 19 pounds the blood begins to advance into all the minute arteries and capillaries, and these vessels are all flushed with arterial blood. The maximum pressure retards the current from the cardiac pump, and the minimum pressure again permits a rapid advance.

This is the state of the arteries and capillaries. With the venous and lacteal system the reverse prevails. The veins absorb appropriate predigested materials from the alimentary canal, and this absorption is much increased by the maximum pressure. By this force, by endosmose, the prepared chyle enters into the commencing lacteals. There is no *vis a tergo* in the lacteals to move forward their contents, and but little, if any, in the small veins to advance their contents. Now here in a close bag we have thousands of minute vessels, venous and lacteal, without immediate muscular environments.

What power has the water in the river to climb into the reservoir? It must be raised to a superior height by a force or pressure, and that force is supplied by the steam-engine. Now venous blood must be lifted into the thoracic region through a second system of divided vessels, all through the liver, thence into ascending vena cava, into right

auricle, and the sluggish chyle must be lifted through the thoracic duct into descending vena cava and right auricle. Here a wonderful mechanism accomplishes seeming impossible results. The diaphragm contracts and establishes among the viscera an active pressure of 25 pounds. This rhythmic force by means of intestinal gases, as does air in a force pump, converts a rhythmic current into a continuous one, and venous blood and chyle are lifted and forced upward into the thoracic cavity; but maximum diaphragmatic pressure of 25 pounds occurs just when thoracic pressure has diminished to about 7 pounds, and this difference of pressure rapidly forces mesenteric, splenic, and pancreatic blood through the portal vein into all the capillaries in the liver, overcoming the friction of small tubes and hepatic veins, and these two fluids, venous nutritive blood and chyle, are elevated and discharged into the right auricle; ready to be sent to the lungs to discharge effete carbonic acid and to be recharged with oxygen. Here is the great culminating force in the economy, alternating with thoracic pressure, and modifying and co-operating with cardiac pressure.

Now these pressures must be maintained in normal force to secure health. Their normal activities are supplied by the necessities of animal existence. These forces can be kept in their greatest vigor by especial exercise, and this intelligently applied becomes an aid to health, physical vigor, and longevity. If these premises are admitted, we shall then be prepared to understand what occupations tend to the development of the highest types of humanity, and why many serious and destructive pathological conditions result simply from living in opposition to the laws imposed upon the animal organism. Preventive measures must anticipate structural lesions, and a perfected physiology will obviate the necessity of relief to many pathological conditions.

If permitted, we shall next take up the mechanism of respiration, and show what exercises best develop thorax and diaphragm, and that upon these associated organs depend a perfect nutrition. If this rhythmic pressure of the diaphragm be a demonstrable fact, and this force has a numerical equivalent estimable in pounds, then whatever impairs this normal force becomes a cause of disease, whether that cause be a want of muscular activity, as in sedentary habits, or constipation, causing excess of pressure and interference with rhythmic action. Those associated muscular actions which co-ordinate with the normal action of the heart become of the greatest importance to digestion and nutrition. Good respiratory force is intimately connected with good diaphragm-

matic force, and out of these two normal activities, co-ordinating with good cardiac action, grow the best possible aeration of the blood and the best possible digestion of all nutritive foods. Out of a perversion of these forces arise poor digestion, malnutrition, degradation of structure, tubercle, fatty degenerations, neuroses, and a host of what is called constitutional diseases, local and general morbid processes. Perfection of form, figure, carriage, grace of movement, vigor of body and mind, health and longevity depend greatly upon the normal display of these three forces, and how to develop them is neither obscure nor difficult.

PEMBROKE, KY.

SOME DISEASES OF THE GLANDULAR TISSUES AT THE BASE OF THE TONGUE—SO-CALLED LINGUAL TONSIL.*

BY J. MORRISON RAY, M. D.

Clinical Lecturer on Eye, Ear, and Throat Diseases University of Louisville. Surgeon to Sts. M. and E. and City Hospital.

Surrounding the upper respiratory passage is to be found a number of accumulations of glandular tissue to which have been given the name of tonsils.

Starting in the vault of the pharynx as an aggregation of lymphatic tissue, under the name of Luschka's gland or the pharyngeal tonsil, it extends on each side toward the orifice of the eustachian tubes, thence as a chain of submucous lymphatics down on each side to the space overlying the superior constrictor muscle, between the palatoglossus and palato-pharyngeus, the so-called pillars of the fauces, where it again becomes aggregated into the faucial tonsil. From these it extends down the lateral walls, between the divergence of the faucial pillars, toward the base of the tongue, where it again aggregates into lymphoid bodies that more or less fill the glosso-epiglottidian fossæ, and thus complete a glandular circle around the pharynx. Some have traced it still further, even into the ventricles of the larynx, where it may form a recognized enlargement.

The pharyngeal and faucial portion of this ring are found in their highest state of development in childhood, and, if they have never been the seat of inflammatory change, diminish in size as the age of puberty is attained, soon after which they disappear altogether, or present slight

* Read before the Louisville Medico-Chirurgical Society June 9, 1893.

elevations marking the base of the original gland. That portion situated at the base of the tongue occupies the space behind the circumvallate papillae, and in front of the attachment of the epiglottis. In the normal state it is observed best by the aid of the laryngeal mirror, yet I have encountered it so enlarged as to be seen by strong depression of the tongue, accompanied by efforts at gagging. With the laryngoscope this tissue appears as a number of elevations scattered in an irregular manner over the tongue, and extending over toward the lateral glosso-epiglottidian folds, with here and there veins of considerable size showing themselves as dark blue lines coursing between the lymphoid collections.

Unlike the faucial and pharyngeal, enlargement of the lingual tonsil generally shows itself in adults. The cases I have seen were between nineteen and forty years of age—the majority females.

Anatomically these glands are identical with the pharyngeal tonsil, consisting of accumulations of lymphatic tissue covered with mucus membrane, with here and there, on the summit of the elevations, depressions that mark the openings of the crypts or follicles. When excessively enlarged it represents two lateral masses, separated by the median raphe of the tongue projecting forward so as to lie in contact with, or even overhang, the epiglottis. Generally, however, we see a number of masses irregularly placed. Within recent years considerable attention has been drawn to this region as the seat of annoying and often persistent discomfort.

Lennox Browne first called attention to a varicose condition of the veins in this locality, giving rise to symptoms of *globus hystericus*. He states that there is frequently concomitant evidence of a varicose diathesis, such as rectal hemorrhoids, varicocele, or varicose veins of the extremities.

Rice and Curtis have reported cases of persistent cough and loss of the singing voice, due to hypertrophy of this glandular tissue. I have seen cases showing varicosity of the superficial veins in this locality, and a number presenting more or less enlargement of the glands. All such cases have not, however, presented symptoms referable to the part, and have improved without treatment of the base of the tongue. A few others I have seen wherein the condition was so very marked that the symptoms pointed so distinctly toward this region as the offending area as to make the indication for treatment unmistakable. The symptoms usually complained of are a sensation as if there was a foreign

body present, with accumulations of excessive quantities of mucus and saliva, and usually considerable cough. These cases are frequently neurotic and dyspeptic subjects, who have been told they were suffering from catarrh or incipient phthisis.

I can best illustrate my subject by relating a few of the well-marked cases I have observed.

Mrs. R., age thirty-nine, wife of a minister from the southern part of the State, consulted me in 1891. She said that she had been told that her trouble was catarrh, but her family feared tuberculosis, since a sister had died two years before, at about her age, with this disease. At the commencement her symptoms resembled those she had had for the past few months—these were a cough, a sense of fullness, with excessive saliva and constant desire to swallow, with a raw, burning sensation low down in the throat (this symptom she emphasized by placing her finger on the neck corresponding with the side of the larynx); her voice was husky, and easily fatigued; she suffered from constipation and dyspepsia, and attacks of eructations from the stomach. On examination the pharynx appeared red, congested, and contained a number of enlarged follicles, no enlargement between the faucial pillars; the nose and naso-pharynx were well open, and the turbinates gave no evidence of contact or pressure. The laryngeal mirror showed the larynx healthy. The lower pharynx was much congested and red; the base of the tongue presented a quantity of hypertrophied gland tissue; this was irregularly distributed—on one side a mass hid the epiglottis. The diagnosis I made was enlarged lingual tonsil, with pharyngitis, the latter probably due to the pyrosis.

I ordered a cleansing solution for use in the atomizer, and gave internally a laxative pill and lactopeptine, with bismuth. She left for home in a few days, feeling better. This continued for a short while, when I advised the use of dilute nitro-muriatic acid. Under this the regurgitation from the stomach was relieved, and the soreness in the throat disappeared. Two months later she returned, complaining of the fullness, cough, and excessive saliva. On inspection the pharyngeal redness appeared much less, but the base of the tongue still presented enlarged tissue. I determined on surgical interference. Painting the parts with a ten-per-cent solution of cocaine, I removed several masses of gland tissue by means of curved scissors and a pair of post-nasal cutting forceps. One piece that overhung the epiglottis was as large as a hazelnut. Some bleeding followed that was checked by hot

water held in the mouth and allowed to be slowly swallowed. A few days later a few tags were noticed, making the surface rough; with the galvano-cautery I destroyed these. The throat was very sore for several days, and I was unable to do more during her limited stay. I ordered a tannic acid and listerine gargle, and advised a continuance of the internal treatment. She wrote me about three weeks afterward that the soreness slowly disappeared, and with it the sensation of fullness and the accumulated saliva, and that the cough was better.

Mrs. X, age twenty-five. I saw her three weeks ago. (Her case suggested to me this paper.) She complained of having been hoarse nearly all winter, and with it a disagreeable tickling sensation that caused much cough. Recently she had much family sickness and anxiety, since which the throat was worse, and felt full, with a constant desire to swallow. On examination the nose and upper pharynx looked comparatively well; the larynx showed thick, reddened cords; the inter-arytenoid space was roughened, and covered with partially dried mucus; the base of the tongue showed three enlarged lymphoid bodies—one, the size of an almond, pressed firmly against the left edge of the epiglottis. I cauterized these well with galvano-cautery, and ordered steam inhalation, and an alkaline solution for the atomizer, to be drawn well down into the larynx. I have not seen the patient since, but understand the throat was quite sore for a week, but since the voice has improved and the fullness in the throat is less.

These two cases are the only extreme ones I have met. An example of a less severe one is the following:

Miss M., age nineteen, was referred to me by a well-known vocal teacher of this city, with the statement that her head notes were bad, and her voice easily tired. The teacher had seen one case where I was able to improve the head notes by relieving a turbinated hypertrophy, and she suggested to this young lady that she probably had some nose trouble. On examination the nose was found free of hypertrophy or septal deflection, and the larynx was normal. I could, therefore, give no satisfactory explanation of her condition, but suggested treatment of the larynx by astringents with a brush, hoping that, by toning up the mucous membrane, an improvement would follow. On examination, preparatory to making an application of zinc chloride to the larynx, I noticed the base of the tongue. It appeared rougher than in health, a number of lymphatics appear enlarged, and the mucous membrane congested. One gland was particularly enlarged, and the follicle on its

surface contained a small whitish concretion. I decided to destroy this gland, and try treatment to this locality rather than to the larynx. I applied cocaine, and with the galvano-cautery I destroyed this gland, the seat of chronic follicular disease. It was sore for only a few days. After this I applied, at three sittings, Lugol's solution and glycerine, after which the treatment was discontinued. Soon afterward I was informed that her voice had improved, and was not so easily fatigued.

I have treated a number of cases where the gland was more or less enlarged, without any improvement in the symptoms of which they complained. The three cases reported were for the purpose of showing the undoubted existence of a morbid condition in this locality that was remediable. I have had but little effect from alterative and astringent applications, and gargles do not reach to the locality.

I am convinced that cases frequently occur, both of acute and chronic follicular disease, yet but slight reference can be found in literature to such a condition. I have recently encountered two cases of acute follicular inflammation of these glands—one, a negro, was in my dispensary service. The second case, Mr. G., had suffered for several days with some pain in swallowing, and it had been diagnosed rheumatic sore throat, and given anti-rheumatic treatment, but his throat had not improved. When I saw him there was no evidence of an acute process in the pharynx or fauces. On using the laryngeal mirror I noticed the base of the tongue on the left side was red, and covered with several follicular exudates. The glosso-epiglottidean fold was edematous, and when the part was touched with a probe acute pain was elicited. Prompt recovery followed a few applications of iodo-tannin solution. There is no reason why these glands should not be subjected to the same forms of disease as affect the faucial and pharyngeal tonsil, such as accumulation of concretions, mycotic disease, etc., but they are often overlooked in searching for the cause of a throat trouble.

LOUISVILLE.

Reports of Societies.

THE LOUISVILLE CLINICAL SOCIETY.*

Stated Meeting, June 13, 1893, Dr. Wm. Cheatham, President pro tem., in the chair.

Dr. A. M. Vance: I will make a continued report. You will remember I reported before this Society at one of its recent meetings the case of a little girl who had a perforation from typhoid fever, the pus working outward and finally discharging at the umbilicus. She has grown rapidly better, is able to walk about a little now. The artificial anus is still discharging fecal matter, but I believe the child is going to get well.

DISCUSSION.

Dr. J. G. Cecil: What do you propose to do in the case?

Dr. Vance: I am going to wait about six months, and if spontaneous closure does not take place, will seek for the opening in the inner wall and endeavor to close it.

Dr. L. S. McMurtry: I have had three cases of fecal fistula after abdominal section. One of them was very large, nearly all the contents of the intestine came out through the abdominal wall, and it continued for seven months. Complete closure finally took place and the woman became entirely well. In the second case the gut was opened in stripping away the pus sac, the woman's condition was so extreme that I could not take time to sew it up. The cavity was packed with gauze, the fecal fistula remained for about nine days, then closed spontaneously, followed by recovery.

Dr. W. O. Roberts: I had one case of fecal fistula following one of my earliest laparotomies, which I attributed to the tube. It did not last so long as the one referred to by Dr. McMurtry; I think it closed up in about six weeks.

Dr. McMurtry: If I were Dr. Vance I would not be in a hurry to interfere with the case he refers to; I believe if he will give it time the fistula will close.

Dr. T. P. Satterwhite: I had a case a few months ago, in a girl fifteen or sixteen years of age, upon whom I operated upon for appendicitis.

*Stenographically reported by C. C. Mapes, Louisville.

Twenty-four hours after the operation the nurse telephoned me that she believed fecal matter was being discharged through the drainage-tube. This was about eight o'clock in the evening. I went out at once and upon reopening the external wound I found no ligature; I sewed up the opening but the tissues were so soft that the stitches would pull out. I again sewed it up with very fine silk, making, as I thought, a good union. The next morning fecal matter came out in considerable quantities, meantime I had consulted with Dr. McMurtry, and he told me to let it alone, which I did; and although the opening was sufficiently large to admit my forefinger into the cecum, fecal matter stopped coming from it and the fistula closed in about three months.

Dr. George W. Griffiths: I have had two fistulous openings following knife wounds. In both cases feces passed through the opening freely, but closure took place without any trouble in two or three weeks.

Dr. J. W. Irwin read the essay, subject, *The American Disease*. [See p. 89.]

DISCUSSION.

Dr. P. F. Barbour: The disease under discussion is certainly an "American Disease," although I believe recent reports show that it is spreading and is attacking Europe. I think its cause is the greatest obstacle we have to deal with in its treatment, as we can not take a man's mind off his business; if we take his mind off his business, we have to give him something else to think about, and that unfortunately, usually is his disease. I believe in cases of this kind massage and electricity are about the best remedies that can be employed. One advantage of this treatment is that it gives the patient something to think about, and it does to a certain extent answer the indications of the case. Very often in these cases I believe the trouble is due to some form of dyspepsia. A great many papers have been written recently upon the subjects of dyspepsia, gastric indigestion, diseases dependent upon malnutrition, etc., and a great deal of light has been thrown upon many obscure diseases. I believe when we know more about the physiology of gastric digestion we shall be able to treat such diseases as the "American Disease" in such a manner that much benefit may be accomplished. It has been found that when the gastric juice is deficient in one respect or another and there is indigestion of the albuminous foods, that certain toxic matters are carried into the intestines, and these toxins or tox-albumens, absorbed by the intestines and carried into the

blood, produce symptoms which are very similar to those of the American Disease, and I believe that by treating the dyspepsia we will very often help this terrible disease.

Certainly the habit that some of us have of reading the newspapers at meal times, carrying our business home with us at night, and thinking of it all night long, is a great factor in producing indigestion, and indigestion is a great factor in keeping up this and other troubles.

Dr. Satterwhite: I agree with what Dr. Barbour has said, except that he has omitted one important point in which I suppose he would agree with me, and that is a systematic feeding. There may be gastric or intestinal indigestion, but no matter which, in the majority of cases there is a decided deficiency in the nourishment.

Dr. McMurtry: It seems to me that this is the same condition of the nervous system which was written about very elaborately by the late Dr. Beard, under the term of "Neurasthenia." Certainly the description given by Dr. Irwin is very accurate. I suppose doctors have this trouble in as large proportion as any other class of brain-workers. Others rest on Sunday, but doctors have no Sunday. I believe in the treatment of the disease under discussion the best thing is for one to cultivate a hobby of some kind. I think one of the best hobbies is fishing or hunting, some athletic sport, something to take a man's mind entirely away from his business occasionally.

Dr. Satterwhite: It is my observation that a good many doctors take Sunday particularly for performing their surgical operations; there seems to be a desire to wait until that day. It seems to me that matters could be so arranged that operations could be performed on other days and make Sunday a day of rest to the physicians.

Dr. Griffiths: If there were more unity among the doctors in giving up Sunday work I think we might have a better time. Compel the public to give us more time. I have had for the last twenty-seven years an office hour from seven to eight o'clock in the evening, and I would give almost any thing in the world to break it up. I remember Dr. Palmer sent around a circular fifteen or twenty years ago, the purport of which was to regulate the time for sending out accounts, reducing the time from one year to three months; the older physicians have acted accordingly. We could have some unity of action in regard to the hours of our work. It seems to me that we might get up a circular of this kind agreeing to do away with Sunday and night business, as far as practicable, and live up to it.

Dr. Roberts exhibited a set of Murphy's buttons and demonstrated their use in gall-bladder and intestinal surgery.

Dr. J. A. Ouchterlony (Double Pleurisy): About two weeks ago a lady came here from a distance with the following history: She was twenty-four years of age, had been married nineteen months, had never conceived, yet there was some little doubt as to the possibility of pregnancy at the time. A year ago she took cold and suddenly developed symptoms of left-sided pleurisy, for which aspiration was resorted to at the time, five times altogether. The last time only two ounces of fluid was withdrawn. At no time, so it was stated, was the fluid purulent, but it coagulated shortly after having been withdrawn, showing that it contained fibrogenous substance. When I saw her I found she had pleurisy of the left side in the third stage; that the left lung was bound down as is usually the case, and was somewhat solidified. There was dullness and bronchial respiration and entire absence of the respiratory murmur. There was no expansion of the left side, the ribs had fallen in, the intercostal spaces were very much narrowed, and the left shoulder was lower than the right. The heart had been displaced apparently to the right, and no apex beat could be found. No impulse could be found, and there was considerable dullness of the lower sternal and the lower right mammary region. Pulse extremely rapid, rose on the slightest excitement, and the heart sounds were muffled. At first I thought it was simply a displaced heart owing to the former pleuritic effusion, but if that had been so, with removal of the effusion the heart ought to have returned to its normal position. So the diagnosis lay between a heart attached or fixed in an abnormal position by adhesions, or else pericardial effusion. I came to the latter conclusion because of the entire absence of the apex beat, absence of impulse, muffled condition of the heart sounds, which were feeble, and the quick, small pulse, which rose with great frequency. The right side gave evidence only of impeded respiration. After having been up here a few days we noticed she had a little pain at the base of the right lung, but there was nothing to be heard. Three days ago, all of a sudden, she developed evidences of acute pleurisy of the right side, and the symptoms increased with great rapidity. However there was no marked rise in temperature, it did not run higher than 100° F., but this morning she had violent dyspnea and was in collapse. Pulse exceedingly feeble, rapid, small, and surface bathed in cold, clammy perspiration; hands and feet livid; lips livid; respiration gasping. Dr. Turner Anderson and myself went

to see her, and we found evidences of effusion in the right pleural cavity, or else there was great increase in the pericardial effusion. At first, in introducing an aspirator of large size, we thought that we were drawing fluid from the pericardium, but we very speedily changed our opinion and came to the conclusion that it was the pleural cavity being emptied. Over a gallon of purulent fluid was withdrawn, and she was relieved immediately. The skin became warm, color became normal, she breathed with freedom and expressed herself as being perfectly relieved. She, however, went suddenly in collapse, and in a few minutes died. I report the case, first, because it is very unusual to find a double pleurisy under such conditions in adults; secondly, because of the difficulty that sometimes arises in differentiating a heart tied down in an abnormal position, from a heart in an abnormal position and at the same time the seat of pericardial effusion.

DISCUSSION.

Dr. J. G. Cecil: At what point did you aspirate this morning?

Dr. Ouchterlony: At the fifth intercostal space, right side.

Dr. Vance: Did you ever see a death primarily from emptying the chest?

Dr. Ouchterlony: Yes, I have seen one, and that occurred under my own care many years ago, before the day of aspirators. I had a case of pleuritic effusion in the right side, and I introduced an old-fashioned grooved trocar. The man died with evidences and symptoms of violent congestion of the lung. He had dyspnea, cough, abundant expectoration of a bloody, frothy fluid. The patient died in a few hours after the operation.

Dr. Roberts: In the case reported to-night, was there any evidence of a communication with the lung? Or was there any pneumonia?

Dr. Ouchterlony: There was no evidence of any opening in the lung. I am inclined to believe that when she first came here she had pneumonia of the left side.

T. C. EVANS, M. D., *Secretary.*

TRICHINOSIS IN BELGIUM.—Between January 14th and February 16th of the present year thirty-nine persons in Belgium contracted trichinosis; thirteen of the cases proved fatal.

LOUISVILLE SURGICAL SOCIETY.*

Stated Meeting, April 10, 1893, Dr. John G. Cecil, President pro tem., in the chair.

Dr. Turner Anderson: (Injury to Hand; Proposed Operation.) This young man five months ago received a cut on the hand from a wood chisel. He suffered very little at the time, and the wound healed. About a month after he began to suffer considerable pain, and the thumb began to swell. He went on working as usual, notwithstanding the inflammation and pain. I think the treatment is plain. There is every appearance of pus, and I believe it will only be necessary to make an incision and clean it out thoroughly. This is what I propose to do.

DISCUSSION.

Dr. A. M. Vance: Dr. Anderson's suggestion as to treatment in this case I believe is the only rational procedure, and there is no doubt in my mind but the trouble will be completely relieved by such an operation.

Dr. W. L. Rodman: (Tubercular Arthritis.) I saw this young man with Dr. Chenoweth, and I am sorry the doctor is not here to give the history in detail. I first saw the patient at the University Clinic, and asked him to come out to my office that I might get the whole history. I have a memorandum on a card which I will read, it being a few points in regard to the history that I was able to elicit from the patient himself: R. C., aged sixteen years; parents living and in good health. Gives no special history of tuberculosis; several brothers and sisters living and in robust health. Two brothers died during infancy. Felt perfectly well until December 1, 1892; at that time commenced to have daily chills about two o'clock P. M., followed by fever and sweats. December 20th, right arm commenced to pain him at the elbow. December 26th, noticed swelling for first time; swelling greater at elbow-joint, but not marked at any point. At that time he thinks the swelling was about half as extensive as it now is. While it was painful, he could use his arm some. Has had a cough since December 1st last. Lost about fifteen pounds in flesh. Arm has not increased in size for six weeks. I would like to have the opinion of the Society as to diagnosis and treatment.

*Stenographically reported by C. C. Mapes.

DISCUSSION.

Dr. Anderson: Is there evidence of disease of the lung?

Dr. Rodman: Yes, in the lower part of the right lung.

Dr. W. C. Dugan: I operated upon a patient having a condition very much like this at the City Hospital during my term of service there last year. Patient had been treated a number of months for rheumatism, and was referred to me from the medical ward. I resected the arm and found it was in a condition of rarefying osteitis; removed the olecranon process, found the bone perfectly soft, and with a pair of forceps I clipped off the condyles, being careful not to interfere with epicondyles to which the lateral ligaments are attached. There was a good deal of edema of the arm, which soon disappeared. This patient has a good limb with almost perfect flexion and extension, and has regained his health.

In regard to treatment in the case referred to by Dr. Rodman, I would excise the elbow and treat it openly with iodoform dressing.

Dr. A. M. Cartledge: I think it is a case of tubercular arthritis, although the shape is a little unusual. The amount of induration on one side seems unusually low, and looks a little curious. I take it that there is very likely synovitis as well as osteitis. I agree with Dr. Dugan that resection is the proper procedure.

Dr. H. H. Grant: From the examination I made of the case I think it is tubercular arthritis. There can scarcely be a doubt about it, but that one doubt would be that there might possibly be some sarcomatous disease of the joint. There is very little effusion.

Dr. Vance: What part would the phthisis play in treatment of the joint?

Dr. Dugan: I should not consider it at all.

Dr. W. O. Roberts: I agree perfectly with the statements already made, that it is clearly a case of tuberculous disease of the joint, and resection is the thing to do.

Dr. Rodman: Everybody has expressed exactly the same opinion that I had already formed in regard to this case. I felt almost positive it was a case of tuberculous disease of the joint, after taking the patient to my office and getting the history. I believe the joint ought to be cut into and very likely resected.

Dr. Vance: (Partial Thyroidectomy.) Here is a specimen I removed yesterday from a young man twenty-five years old. The tumor was

just over and a little to the left of the larynx. When an incision was made, the cartilages were completely exposed. At the time I first saw the case I thought the enlargement was part of the thyroid gland. I saw a similar case in this city sometime ago. The growth was removed, which looked and felt very much like the thyroid gland. The history was substantially the same as that of the case reported to-night. In the operation yesterday I found a great blood supply to the tumor, three very large vessels. Owing to this, I was more convinced than ever that I had removed a portion of the thyroid gland. Dr. Rodman saw the specimen shortly after the operation, and thought the trouble was probably lymphatic. Microscopical examination, however, proved it to be the thyroid gland. I will quote the microscopist's report:

LOUISVILLE, KY., APRIL 9, 1893.

Dear Doctor: The growth left me has all the appearance macroscopically of thyroid gland tissue, and thus it proves itself to be upon microscopical examination, consisting of a framework of fibrous tissue inclosing glandular spaces, lined with small, flat epithelial cells. The glandular spaces are in part filled with a homogeneous material (colloid); others are filled with round cells (lymph cells). Diagnosis, Thyroid gland.

LOUIS FRANK.

DR. A. MORGAN VANCE.

This is the second case of the kind I have seen in the last twelve months.

DISCUSSION.

Dr. E. R. Palmer: Was there much hemorrhage during the operation?

Dr. Vance: There would have been had I not used clamps.

Dr. Rodman: I saw Dr. Vance shortly after he removed this growth, and he asked me to look at it and give my opinion upon it. I looked at the specimen rather carefully. It was not opened at the time, and I told him after my examination that I thought it was a lymphatic gland. I am more certain of that position now since it has been thoroughly opened, notwithstanding the microscopist's report. It has every appearance in the world, color and every thing else, of a lymphatic gland, and I am reasonably sure that is what it is. It does not look like thyroid tissue. I have dissected a hundred thyroid glands, and am sure they did not have this appearance. The history of the case furthermore points clearly to lymphatic enlargement rather than to disease of the thyroid gland. We do have growths of the thyroid that occur sometimes from an accessory portion, but, as I have said

before, this does not look any thing like thyroid tissue. Thyroid tissue is purplish red, about the color of liver.

Dr. Cartledge: I would suggest that Dr. Vance have Dr. Frank make some additional sections in this case. If it is thyroid tissue it has every appearance of having undergone malignant degeneration. I agree that it does not look like thyroid tissue. I know of no change that the thyroid body is subject to which would give it such an appearance, unless it be sarcoma. I have never seen so much connective tissue in any form of goitre as there is in this case, and I am not aware of any pathological condition that would give it this appearance. However, the microscope ought to show just what it is.

Dr. Vance: Goitre affects the central lobe of the thyroid, the shape being caused by pressure of the skin over the hypertrophy. In the case reported by me the thyroid gland on every side looked like this tissue when it was exposed. This is evidently the isthmus hypertrophied.

Dr. Rodman: Benign growths from the thyroid gland are practically unknown. The only benign growths or enlargements that we have of the thyroid are originally cases of hypertrophy or bronchocele, and then cystic degeneration of the gland. Malignant disease does sometimes occur, but it is exceedingly infrequent, so infrequent that I doubt if any gentleman here has ever seen one. I have never seen one; and in the absence of benign growths from the thyroid, the comparative rarity of malignant growths of the thyroid, with the history of this case, I feel quite safe in saying that it is an enlarged lymphatic gland.

Dr. Vance: I have very little to add in closing. Certainly I would rather take the testimony of Dr. Frank, who is recognized as one of the best and most accurate microscopists in the city, after a careful microscopical examination, than the opinion of Dr. Rodman, or, in fact, anybody else, based upon a macroscopical examination of the specimen. If Dr. Rodman will specify some anatomist that he would like to make further investigation of the specimen, I shall be very glad to send a portion of the growth to him, or, if he prefers, I would be glad to divide the specimen with him, that he may have it examined by anybody he desires.

Dr. Grant: (Intestinal Resection.) I have a specimen here which is the result of an intestinal resection made upon a living animal two weeks ago. After killing the animal I removed about eight inches of

the gut embracing the portion resected, which has not yet been opened, as I wished to exhibit it here with a view of showing how much the lumen of the bowel is diminished, if any, and also to see the result of the resection generally. The animal was thoroughly anesthetized, the incision made, and several inches of the intestine exposed. Resection was quickly done by the aid of the clamp devised by myself, which I present here for your inspection, and which was also shown at the meeting of the Southern Surgical and Gynecological Society several months ago. The animal was under chloroform thirty-five minutes. Eleven minutes were occupied in suturing the intestine. The ends were invaginated in the usual way, continued suture being employed. By an examination of the specimen you will see there is very little contraction; the sutures have been completely buried; there was no peritonitis; the animal did remarkably well after the operation, and the result is perfect. The operation was done very leisurely, and I am satisfied it could be easily completed in twenty minutes. No plate of any kind was used. I have made this experiment several times, using only one line of suture, and the result has been perfect, except in one instance.

This clamp is used only for resections. The ends of the intestine are laid parallel with each other, and the suturing done while the clamp is *in situ*. It shortens the operative steps very much, renders approximation of the openings absolutely accurate, and defines the limit of the fenestra beyond chance of error. Such a clamp takes the place of skill to a considerable extent.

DISCUSSION.

Dr. Dugan: The clamp certainly shortens and simplifies the operation very much indeed. The clamp designed by Dr. Grant is the best contrivance for the purpose that I have ever seen.

Dr. Roberts: (Vulvo-vaginal Tumor.) This specimen is simply a vulvo-vaginal gland dissected out to-day. The patient was a young widow who noticed this growth three years ago, and claims that a short time before the appearance of the growth she was considerably bruised during coitus with her husband, that there was a good deal of swelling about the parts, and some time after that while bathing she noticed this lump. She has been worrying a great deal about the matter, simply from the fact of the growth being there, and came to the city to have it removed. I have seen a good many such cases, and have usu-

ally laid them open, not finding it necessary to dissect them out. However, in this case the patient was very anxious to have it removed, which was done very easily and quickly.

DISCUSSION.

Dr. Rodman: Was the growth on the left or the right side?

Dr. Roberts: On the left side.

Dr. Palmer: I see quite a number of these cases, and the question asked by Dr. Rodman brings up a point that I had not thought of before. In three of the cases recently seen by me the enlargement was on the right side. I have never removed but one of them *in toto*. When this complete operation is done there remains a depressed, hard cicatrix at the point of removal, which is entirely avoided when these glands are simply opened, curetted, and packed; and provided the operation is thoroughly done the cure is equally assured.

With reference to the etiology, I believe almost invariably that the condition is of gonorrheal origin. It is hard to say that this is absolutely the case, but I believe in the vast majority of cases it can be traced to gonorrhea. The usefulness of the gland is permanently destroyed by these enlargements, so far as future function is concerned, whether they be dissected out or curetted and packed. The secretion is unilateral afterward; that is, confined to the side not diseased.

Dr. Rodman: I have seen, I think, five or six cases of enlarged glands of this character in my experience, and my observation has been different from that of Dr. Palmer. I have seen but one on the right side. I would like to ask Drs. Anderson and Cecil what their observation has been in cases occurring after labor as regards the side affected, and their explanation as to why the left side is more frequently diseased than the right. It has not only been my experience that the left side is far more often affected than the right, but in looking the matter up several months ago I found that the vast majority of these enlarged glands occurred on the left side. The only case I ever saw occurring on the right side was the last case I saw, which was two or three months ago, a patient of Dr. McDermott. The enlargement was noticed soon after childbirth, patient forty-five years of age.

My experience differs again with that of Dr. Palmer. I do not think I have seen any cases where they could be traced to gonor-

rhea. Most of the cases I have seen have been after childbirth, in a class of patients above suspicion.

Dr. Anderson: With reference to the location of these enlargements, I do not think I have seen them more frequently on the left than on the right side. Concerning the etiology, it is my opinion that the majority of them occur from gonorrheal infection. At least I have seen more cases among prostitutes than any other class of women. There is another point of some importance in connection with the etiology. Occasionally after perineorrhaphy, obstruction of the external duct is sufficient to cause cystic degeneration of the gland, which we must recollect is of the same character as the mammary and other glands of the body, and just as liable to undergo cystic degeneration. I have a case now that came to me a few days ago with a tumor in the left side of the vagina, which I diagnosed without any difficulty as an enlarged vulvo-vaginal gland, which has probably undergone some kind of degeneration, as it has attained a considerable size. This patient was operated upon in Cincinnati for lacerated perineum, and it is probable there is obstruction of the external duct, which we know opens just within the ostium vagina. I do not expect to find an abscess, but believe the function of the gland has been interfered with by occlusion from the operation of perineorrhaphy. The case was a satisfactory one as regards the operation, but it has probably obstructed the gland. This is a matter that ought to be taken into consideration in perineorrhaphy, but at the same time I do not see how it can well be avoided.

With reference to the point raised by Dr. Palmer concerning the treatment of these cases (incision and packing, and in that way preserving the symmetry of the parts, preventing shrinkage or depression), I do not know that my attention has been especially directed to that. The usual operation is to simply incise the gland, pack, and let it heal from the bottom; but in the case just referred to, upon which I shall operate in a few days, I believe I will adopt the plan followed by Dr. Roberts, and dissect out the gland bodily. I think this is advisable, owing to the size of the gland.

Dr. J. G. Cecil: The point made by Dr. Palmer seems to me to be the correct one in regard to the etiology, as far as my reading and observation go, that these enlarged glands are largely due to gonorrheal infection. The point made by Dr. Anderson concerning the class of patients I think will be borne out by observing the patients

in which these troubles are usually found. Certainly I have seen more in prostitutes than any other class of women. I do not see how they can follow as a result of labor, unless it be in the manner already described by Dr. Anderson as following the operation of perineorrhaphy; that is, after the duct was torn across in a lacerated perineum, then we might have occlusion of the duct and cystic degeneration result. I can conceive how that might follow as a result of labor, but I can not see how there could be any other method of degeneration or abscess as a result of labor.

I was quite impressed with the description or method of operating described by Pozzi. It is sometimes very difficult, in dissecting this gland out, especially when it is simple cyst, to prevent rupture. As long as we can prevent rupture, dissection is easy enough; but if rupture occurs then it becomes more difficult, then complete dissection is advocated, it being difficult to follow the cyst wall after it is empty. His method is described about as follows: Introduce a trocar and canula, withdrawing the fluid before he attempts to operate, fill it with a warm solution of paraffine; then the application of cold converts the paraffine into a solid tumor, which makes a nice ground to work upon.

I am inclined to the belief that the total obliteration of these glands is the proper treatment. Of course the function is destroyed if an incision is made and the gland packed. If there is an abscess or cystic degeneration, they are of no further use, and might as well be removed. I have never noticed any particular difference in the two sides, and think they are as apt to enlarge on one side as the other.

Dr. Roberts: I have seen a number of these cases occurring in other than prostitutes. I can recall now three cases in newly married women. This, I take it, is cystic degeneration. I do not think there is any pus in it; it has existed too long, something over three years.

(The tumor was opened by Dr. Roberts and found to be cystic.)

Dr. Joseph M. Mathews: (Disease in the Sigmoid Flexure, with Report of Cases.) About one year ago I had the honor of reporting to this Society some investigations that I had been making of diseases in the sigmoid flexure. The paper elicited considerable discussion, and I was asked to prolong the report at the following meeting of the Society. Inasmuch as the subject was treated at length in my work on Diseases of the Anus, Rectum, and Sigmoid Flexure, which appeared shortly thereafter, the second report was never made. From the

friendly reviews of this chapter in the book, and from many letters of commendation that I have received from the profession, I take it that the discussion of the subject was not inopportune. This paper is intended only to give a recitation of some cases that have fallen under my observation lately, and to mention some procedures looking to the surgical treatment of the same. Although recognized from all time that the sigmoid was a favorite seat of disease, but little was done for its treatment, either in a medical or surgical way, until recently.

As far as my knowledge goes, Dr. W. T. Bull was the first to successfully remove the sigmoid flexure for malignant disease. A few months ago Dr. Lange reported three cases of a similar kind, with one success. It must be understood that success means, at least in Dr. Lange's cases, the survival of the patient from the operation. The time is too short to say whether the eradication of the disease is effectual. Dr. Bull claims that his patient lived five years after the operation. In a note to me concerning the case he says: "The carcinoma was excised in January, 1887; she was in good health up to October, 1891, and there was no recurrence at the autopsy in December, 1891, being nearly five years."

Senn has never been a believer in colotomy for any condition, but he has devised other operations to meet the demand. He has anastomosed the ileum into the rectum and also the colon to the rectum successfully, and claims as a result that if stricture of the sigmoid is to be overcome his operation would be preferable to an artificial anus, if the opening where the anastomosis was made did not with time contract too much.

To carry out the idea of Murphy, that by using his button anastomosis of the intestine could be made, either end to end or lateral in a few minutes, Dr. Joseph B. Bacon, of Chicago, has just recently been making some very interesting experiments looking to the surgical treatment of non-malignant stricture of the sigmoid flexure or rectum. Because of the importance and newness of the subject I will be permitted to quote freely from a late article by Dr. Bacon describing the method:

"The operation consists in completely severing a portion of a loop of small intestine that is lying in proximity to the rectum, and anastomosing each end with the rectum so as to form a new channel around the stricture. The mesentery of the severed piece of gut is left intact. A piece of intestine is selected from the loop at a point where the mes-

enteric blood-vessels supply a large nutrient artery for each end of the piece to be transplanted. It is necessary to remember, in cutting out a piece for transplanting, that it must be long enough to extend from a point below the stricture to a point above the stricture where the rectal wall is not too much thinned by ulceration, and also to remember that the button to be inserted into each end will shorten the piece about one inch and a half. The operation is completed by scarifying the approximated surfaces of the rectum and transplanted piece of gut, and suturing them together so as to have the two walls cemented into one firm septum. At a subsequent operation this septum is removed by compression forceps, and the lumen of the rectum and transplanted piece is made into one cavity, and the sloughing out of the compression forceps will destroy one half of the stricture, together with the septum, thus putting an end to the contraction of the cicatricial tissue forming the stricture. The mesentery of the transplanted piece of gut is sutured in close approximation to the parietal wall, to prevent a possibility of a loop of intestine sliding under it and becoming strangulated. A Murphy button is now used to make an end-to-end anastomosis of the gut from which the transplanted piece was resected, and its mesentery sutured carefully so as to leave no opening for hernia to occur."

I will make this report by Dr. Bacon suffice for any further mention or discussion of the surgical treatment in such cases, reserving the right to discuss this method in some future article.

There are several conditions which, if left alone, will produce such pathological changes in the sigmoid flexure as to call for the surgical interference as suggested by Bull, Senn, or Bacon. And yet, if these conditions are recognized early, such ultimate results can be prevented. I must confess that after a stricture has formed at the sigmoid or in the rectum in the great majority of cases no good can come from the treatment of the stricture *per se*, and recourse must be had to such procedures as those mentioned in this paper; and in this day when such aseptic surgery can be done in the peritoneal cavity I see no reason why such attempts as suggested by Dr. Bacon should not be undertaken. But, as prevention is better than cure, I will conclude my paper by dealing with the treatment of such conditions as give rise to the necessity of such operations.

The sigmoid flexure is peculiarly liable to local disease. Outside of malignant affections its anatomical arrangement is such that it is made the receptacle of the feces, both as the mass is attempting to pass out

in the act of defecation, and the remaining portion is pressed back by an anti-peristaltic movement. Hence, it is no wonder that it is subjected to congestions, inflammations, ulcerations, etc., and these combined frequently establish non-malignant strictures. I have tried to demonstrate in a former article that the flexure was often, I might say commonly, the seat of impaction by feces, and the fatality of such impactions sometimes you all can attest. In addition to many cases of sigmoid disease that I have already related, I desire now to call attention to but a few:

CASE I. Mr. J., aged twenty-eight, by occupation a civil engineer. About five months ago he complained of a slight diarrhea. He consulted a physician, who gave him the usual remedies for such cases, but the discharges increased from four or five daily to twelve or fifteen in the twenty-four hours. His condition growing serious, and his disease not responding to internal treatment, his physician sent him to me, thinking that the cause might be found in the rectum. His diarrhea had now continued five months, and he had lost forty pounds of flesh; no energy, and all appetite gone. An examination was now made of the discharges, and they were found to be composed of blood, mucus, and pus; not dysenteric, as no elevation of temperature or pulse occurred at any time. An examination of the rectum revealed an extensive ulceration, beginning about four inches up, and extending evidently into the sigmoid flexure. This man gave no history of syphilis. I had him discontinue all internal medication, go to an infirmary, and observe perfect rest in bed, first giving him a free purge. I then washed out the sigmoid with hot water. He was put on a special diet, and the local treatment begun, which consisted in depositing in the flexure daily one ounce of fluid hydrastis diluted with two ounces of water. From the first injection the discharges began to assume natural condition, and at the end of ten days all mucus, blood, and pus had disappeared. In this time his appetite had returned, and he began to take on flesh, although on a liquid diet. At the end of two weeks he left for Chicago with directions to inject the sigmoid every alternate day.

This case is but a sample of a number that I had to report, but my time being limited I will make this one suffice for the evening.

DISCUSSION.

Dr. Grant: Could the small bowel be made to do the duty of the rectum in case of anastomosis? Would not the fecal matter block up

below where the transfixion was effected? Would it not be better, in other words, to make an artificial anus as it is now made, for the relief of these conditions?

Dr. Mathews: I suggested that it might be better than a colotomy, and for that reason also suggested that it would be better to anastomose the sigmoid flexure or the colon to the rectum, as practiced by Senn, than to attempt the operation suggested by Bacon.

Dr. Rodman: I think Dr. Mathews has called our attention to a very important matter; that is, flushing the sigmoid flexure. For this purpose I believe the rectal bougie preferable to the tube, as the latter is liable to curve upon itself. I have seen harm result from use of the tube. I once made a *post-mortem* upon a patient of a medical friend who had been treated by local applications for dysentery through a rectal tube fully eighteen inches in length. The patient died of peritonitis. In making the *post-mortem* I found the belly full of fluid, soap-suds, etc., used in the injections, which had passed out through a perforation of the gut made, I think, by the tube.

JAS. S. CHENOWETH, M. D., *Secretary.*

PAN-AMERICAN MEDICAL CONGRESS.—It gives us pleasure to be informed that there is to be organized a Medical Publishers' Association in Washington during the meeting of the Pan-American Medical Congress, which convenes September 5th.

Such an organization, if properly formed, will not only be a protection and benefit to the publishers of medical journals, but to the advertisers as well. While the publishers of many of the medical journals are also editors, and probably belong to the Association of Editors which meets simultaneously with the American Medical Association, they certainly must recognize that there are matters pertaining to the business and financial interests of the journals that do not come within the purview of the Editors' Association. We understand the object of the Publishers' Association shall be for the better protection of legitimate advertisers and the publishers, and is not in any way to take the place of or interfere with the work of the Editors' Association. Such being the case, the organization of the Publishers' Association should meet with their hearty co-operation, and we trust that editors will take notice of this proposed movement. Should they themselves not be publishers of the journal they edit, we hope they will advise their publishers of the meeting to be held in Washington, September 5th, urging them to be present and give their co-operation to such an organization as shall be for their mutual protection.—*Medical Review.*

Foreign Correspondence.

LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

A New Light for Collecting Wounded ; The Late Sir Rowland Hill ; A Protection against the Sun ; A Proposed Lottery ; The Royal Wedding and the Streets ; Cholera and Flies ; The Removal of Rectal Tumors ; Charitable Bequests ; A Case of Yellow Fever.

A new search-light apparatus has been invented in Germany intended to be used on the field of battle for the purpose of discovering wounded soldiers. It consists of a pole which extends in telescopic fashion to a total length of 25 yards. This pole, which is made of aluminum, is erected on the ground to be searched, being kept steady by wire ropes fixed to tent pegs driven in the ground. The light, which is not necessarily electric, but may be either oil or gas, is placed at the top of this high pole, and above the light, spread in umbrella fashion, is a large white reflector. Owing to the great height of the pole the light thrown downward by the reflector illuminates a very large space of ground and in a much more effective manner than when an ordinary search-light, such as is used on ship board, is used.

Sir Rowland Hill, the originator of penny postage, breathed his last at a house in Hampstead which now forms part of the establishment of the Metropolitan Asylums Board's Northwestern Hospital, where recently was unveiled a tablet erected by the Society of Arts, and bearing the inscription, "Sir Rowland Hill, K. C. B., originator of the Penny Post, lived here 1849-1879; born 1795, died 1879." A granddaughter of Sir Rowland inaugurated the memorial.

Attention is drawn to a novel expedient as a sunstroke preventive. A resident of India, knowing the difference between the heat and chemical rays of the sun and their distribution in the solar spectrum, had noticed that exposure to heat rays emanating from a source of low chemical activity, even when the temperature far exceeded the maximum ever recorded in the direct rays of the sun by a black bulb thermometer, never produced injurious results, whereas men working with powerful arc electric lights constantly suffered from affections apparently identical with those caused by the direct solar rays, though the radiant heat emitted by these arcs was comparatively insignificant. The writer therefore concluded that sunstroke and sun fever were not so much due to heat of the sun as to the chemical power of its rays, therefore by protecting the human body by any color between yellow and ruby red would protect it the same degree as the photographer protects his plate. Experiment showed that it was immaterial whether the

yellow or red wrapping was placed inside or outside; he had all clothes and hats lined with cheap native material of a good orange hue. The experiment proved completely successful. On one occasion the experimenter marched 600 miles across the Bikar Desert at the end of March in such intense heat that even the camels and their native attendants suffered. He found that it was only the yellow lining that saved him. It is stated that the Government is making experiments in India with helmets lined with orange; but as more injury is caused by the action of the sun on the body, that is, through the liver and heart, than through the head, it is suggested that the men's tunics should be lined with a thin yellow material.

Baron Nathaniel de Rothschild, who recently made over a castle and park near Reichenau, worth five millions florins, to the trustees of the Vienna Hospital for Consumptives, has had to withdraw the generous gift in consequence of objections raised against it by the burgomaster, the townspeople, and visitors of Reichenau. The Baron has therefore agreed to the starting of a lottery with the castle and park as the principal prize. The proceeds will be given to the trustees of the hospital.

Considering the hundreds of thousands of persons who were upon the streets in London upon the occasion of the marriage of the Duke of York, and the intense heat to which many were unavoidably exposed, and in some cases for several hours, the cases of illness and accident reported at the hospitals were comparatively few. At Westminster, Guy's, St. Thomas', and St. Bartholomew's there were none. At St. George's a great many instances of fainting were recorded, all successfully dealt with except that of a woman suffering from heart disease, who succumbed. By far the most common form of mischief was that of fainting, due to the bright sunshine, the heat in the sun's rays reaching 150 degrees. The St. John's Ambulance Corps rendered timely assistance in several instances.

In some recent experiments flies have been found to be most successful as infection carriers of the cholera bacilli. A fly which had been infected by being put on a mass of cholera bacilli was placed on a piece of beef, which after an interval was examined. It was found to contain an enormous number of living bacteria. A finger infected with cholera bacilli was held in the air for seven or eight minutes until it was quite dry. An hour afterward the finger was rubbed on some dry roast meat. Here also a large number of bacilli were developed. After an hour and fifty minutes had elapsed no more living bacilli were developed. From these experiments the often-taught lesson was deduced that in time of cholera epidemic the most scrupulous cleanliness is the best safeguard.

Mr. Rickmuss I. Godlee, in cases of excision of tumors of the rectum, instead of placing the patient in the ordinary lithotomy position, finds it better to place them on the face close to the side of the table, the right thigh extended, the left hip flexed, the thigh hanging over the side of the table, and the knee resting on a chair. In cases where the tumor is so high up that it is necessary to enlarge the anus Mr. Godlee thinks that those who have not adopted this plan will find it worthy of a trial.

The Committee of the Royal Humane Society has published the following cautions for the benefit of bathers: "Avoid bathing within two hours after a meal. Avoid bathing when in any way fatigued. Bathe when the body is warm, provided no time is lost in getting into the water. The vigorous and strong may bathe early in the morning on an empty stomach. Those who are weak had better bathe two or three hours after a meal.

Mr. Solomon Bifus has died leaving personal estate valued at over £79,000. He leaves £210 to be divided among various charities. The Metropolitan Free Hospital and the London Hospital receive £10 each, the Jewish Lying-in Hospital £20. It is reported that the will of the deceased is about to be contested on the ground that undue influence was exercised, causing him to leave so much to the cause of charity.

Dr. Schuster, of Aix la Chapelle, has published a pamphlet entitled "When May Syphilitics Marry." Dr. Schuster says he is in the habit of sanctioning marriage if, after careful examination, no symptoms of the disease can be discovered, and two of his efficient courses have been taken, although he admits that even after two courses recovery may occasionally not be absolute; hence, if a person intending to marry is willing to take additional precautions by waiting four whole years, he should be encouraged to do so.

A large steam yacht has arrived at Cowes, Isle of Wight, from the West Indies, with yellow fever on board. It appears that on the voyage home the steward was attacked and died. At the present time another of the crew is lying dangerously ill.

LONDON, July, 1893.

Pediatrics.

In Charge of Henry E. Tuley, M. D.

SIX CASES OF POLYDACTYLY.—Dr. J. W. Ballantyne reports six cases of polydactyly, in two cases the hands only being affected; in two the feet only; and in the remaining two both hands and feet were provided with supernumerary digits. These cases are described in detail. The author concludes: "I am inclined to look upon supernumerary digits as truly teratological, as very minor manifestations of the same process which, in its most marked form, results in the production of double monsters. The process can at present only be vaguely indicated as one of exuberant vegetative activity." (*Archives of Pediatrics*, July, 1893.)

DR. S. E. MILLIKIN (in N. Y. Polyclinic for June) contributes an interesting article on the "Diagnosis and Treatment of Hernia in Children."

He fully describes the inguinal, femoral, and umbilical varieties, which, for all practical purposes, he states are all that occur during childhood. He uses the "Lank" truss in children in the inguinal variety, but never after the child begins to walk. Cuts illustrating its application are presented.

In all cases where the truss has been worn a year by a child which is otherwise healthy and over five years of age, he advises operation.

He warmly advocates the use of Bassini's operation for radical cure. A light dressing of sterilized gauze applied by spica bandage is worn by patient for a month after leaving bed, after which all support may be left off.

For the umbilical variety he uses a slightly convex pad one inch in diameter, held in place by a broad strip of adhesive plaster which entirely encircles the body. He considers the operative treatment of this variety rarely necessary.

He advises the use of the French (or same side) truss for treatment of femoral hernia, not having found a case requiring operative treatment.

VALUDE ON ASCARIDES LUMBRICOIDES: ESCAPE BY THE UMBILICUS.—A boy, aged fourteen months, was seen on October 14th. He had some inflammation about the umbilicus, the lower half of the umbilical cicatrix being swollen to about the size of a pea, reddened, and with a moistened ulcerated surface. There was no redness or swelling. While the case was being examined slight movements were observed in this little tumor, and presently there escaped through a break in its surface a small lumbricoid worm; a second one was soon voided in a similar way. Both were of a grayish-white color, eight to ten centimeters long, as large as a large stylet, and very active. They were quite dry, nor was their escape accompanied by any loss of fluid.

The patient seemed perfectly well and healthy. He had never been sick, and had had no colicky attacks; had been fed quite largely on weak soup and bouillon, as the mother's milk was deficient. He passed a round worm per rectum in the last week of September, and a week later the umbilicus began to swell.

The use of santolin seemed without effect. Some days later a few more worms were expelled in the natural way, and the child made an uneventful recovery.—*La France Medicale*; *Epitome of Medicine*.

DENTITION AS A CAUSE OF DISEASE.—Dr. Sejournet (*Revue Mensuelle des Maladies de l'Enfance*, Paris, April, 1893,) gives an interesting series of statistics, extending over five years, in regard to the so-called maladies of dentition. He concludes: Sixteen and a half grains of arsenious acid, in a period of seventy-five days. At the end of that time the patient was tender to the touch, and walked stiffly. He rapidly began to walk with difficulty, the knee-jerk disappeared and the legs became flabby. The faradic excitability of the nerves was diminished, and there was beginning reaction of degeneration. He also had pigmentation of the skin.—*Epitome of Medicine*.

PERIODS OF INCUBATION AND INFECTIVITY.—A supplement to Vol. xxv of the Transactions of the Clinical Society of London, contains a report on the above. (British Medical Journal, No. 1688, p. 958.)

Diphtheria. Eighty-seven cases considered. Conclusions were that in the large majority of cases infection was attributed to personal intercourse with the sufferer or convalescent. A person may be infected by a patient suffering with diphtheria (*a*) in the incubative stage, (*b*) during the developed attack, (*c*) for a brief period of long, but uncertain and probably varying duration after apparent recovery. In 27 of the cases considered the exposure to contagion was for a short period on a single occasion, and the incubative period was seven days or less. In 63 cases the period was four days or less.

Morbilli. Of 36 cases, 52 per cent, the interval between the known exposure to the appearance of the rash was exactly 14 days, in 78 per cent the period was 13, 14, 15 days. In only three cases did the period exceed 15 days. The interval may be 17 or 18 days, or as short as 7 days, but rarely.

Parotiditis. In 24 cases, 14 of single short exposure. Period of incubation was 3 weeks—a day or two more or less in 10 cases.

Rotheln. Eighteen days is probably the usual period.

Scarlatina. One hundred and forty cases were considered. It is concluded that the period of incubation is some time between 24 and 72 hours.

Varicella. It is usually 14 days.—*Medical News.*

CASE OF MEDIASTINO-PERICARDITIS IN A CHILD; SECONDARY EMPYEMA; OPERATION: DEATH.—In International Medical Magazine, Vol. 11, No. 5, Dr. William A. Edwards, of San Diego, California, reports a case as described above. Patient was a female, aged six, and complained of constant pain, with marked exacerbations over left costo-sternal region extending from about the mid-sternal line to a little below the costo-xiphoid angle; slight impairment of percussion resonance over this region. Cervical veins were distended; circulation irregular, temperature 100°. After remaining in this condition for thirty days symptoms became more aggravated, dullness was marked, respiration and circulation much interfered with; enlargement of liver; high temperature; albuminuria. Pus obtained by an exploratory puncture over normal position of apex beat of heart. Nine ounces of pus removed through an incision. Within a fortnight it became necessary to make a secondary incision for an empyema, sixteen ounces of pus being removed.

On January 30, 1893, resection of three ribs was done for more complete drainage. Child reacted nicely from operation but died one week later from prolonged drain and exhaustion incident to so much suffering and suppuration.

Autopsy showed case to have been one of primary mediastino-pericarditis, which within two months was followed by a purulent pleurisy.

The author has collected a number of cases which he reports in brief.

ACUTE INTUSSUSCEPTION IN AN INFANT EIGHT MONTHS OLD; OPERATION: RECOVERY.—Patient was a well-grown male infant, in good health until onset of symptoms which began suddenly, child screaming and stretch-out its legs. The day following neither the feces nor flatus were passed. An examination showed tympanites and an elongated tumor in right linea semilunaris. Examination *per rectum* negative, but the bowel contained some blood. Under chloroform ten ounces of warm water was injected in lower bowel by rubber tube and funnel held at a height of two feet and a half. Abdomen was distended, but tumor not reduced. Injection repeated with twelve ounces of water held three feet high. Laparotomy was decided upon. An incision made five inches long in left semilunaris; tumor removed from abdomen, the intussusception proving to be of the ileo-colic variety. There were no adhesions present, but the bowel was deeply congested and thickened. Patient was under the anesthetic thirty-five minutes, and was put to bed in good condition. Slight reactionary temperature to 102.2° F., but it soon subsided. Recovery uneventful. The following points were given in discussion of the case by the author:

It is futile to expect success in infants and children unless abdominal operations are done with the greatest expedition.

Shock is the great cause of fatality.

Peritonitis is generally caused either by infection during operation from without, or from the intestine, owing to rupture, ulceration, or gangrene. Neither should occur.

Injections of warm water should be tried under an anesthetic to accomplish reduction; these are generally futile after forty-eight hours. They are successful only in ileo-colic, ileo-cecal varieties, and in those of rectum and large intestines.

The signs of acute intussusception are clear and unambiguous. They are acute intestinal obstruction plus the discharge of blood and mucus from the bowel, plus a tumor.

Blood is passed in half these cases, and a tumor is often felt either by the rectum or in the abdomen.

As regards safety in operating, the following procedures with the order of preference, as follows: Incision, incision and amputation, resection, and immediate suture, extrusion and artificial anus without resection, and artificial anus preceded by resection.

Resection with immediate suture is an ideal operation.—*C. B. Lockwood, F. R. C. S., Eng.; The Lancet.*

IMMIGRATION.—More immigrants were landed in New York during May than during the same month last year by about six thousand, the total number being over seventy thousand.

THE AMERICAN PRACTITIONER AND NEWS.

"NEC TENUI PENNĀ."

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No. 3.

D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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This journal is devoted solely to the advancement of medical science and the promotion of the interests of the whole profession. Essays, reports of cases, and correspondence upon subjects of professional interest are solicited. The editors are not responsible for the views of contributors.

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THE PAN-AMERICAN MEDICAL CONGRESS.

As has been freely and fully advertised, the Pan-American Medical Congress will convene in Washington, D. C., September 5th, 6th, 7th, and 8th. The success of this daring venture in a scientific way seems to be assured; but whether or not it shall prove an expensive experiment to its projectors and participators is for the shadowy future to reveal.

That the financial stringency of the times should tend to constipate the movements of those who "keep the medical ball a rolling" at our societies and occasion a slim attendance is more than a thinkable hypothesis, and in view of this the officers are appealing to the professional and national patriotism of the physicians of the United States by every legitimate means. An attractive scientific programme has been prepared, and several great men will read papers and take part in the discussions.

To enhance the interest of the Congress some questions not pertaining to science, but of great professional interest, will be called up for discussion. For instance, the distinguished editor of the British Medical Journal, Mr. Ernest Hart, has consented to come and deliver an address. The nature of this address the author sets forth in a letter to the Secretary-General, a copy of which Mr. Hart has had the kindness to send us. He writes:

After carefully thinking the matter over, and especially after what I gather of the peculiar position of matters in New York City, and perusing the draft report of the American Medical Association on the subject of the proposed amendments of the Constitution and Rules of the Association, I have come to the conclusion that the most useful subject on which I could give an address would be "Medical Etiquette, the best Protection alike to the Public and the Profession." In that way I shall be able to raise the whole question in what would, I think, be a very useful manner, and I have no doubt that if it is duly made known beforehand some of the New York physicians, such as Dr. Roosa, and perhaps Dr. Paul Mundé, and others, who are assailants of the Old Code, would probably come up to Washington, so that we might have an interesting discussion, and they would have to show their hands and defend their position, which I think they will find not very easy; but in that I may be mistaken. At any rate it will raise the question and lead to a debate which may be useful both to the profession and to the public, and would give, if it is known beforehand, a considerable interest to that part of the proceedings, and the Congress, both in America and here. The address need not be long. I could reduce it to half an hour without detracting from its main points of interest.

This will make welcome to the Congress the disaffected workers under the New Code in New York City, who, having been barred out of the American Medical Association, snubbed out of the International Medical Congress (American meeting), and kicked out of the old New York State Society, may justly complain of rough treatment. It is to be hoped that they will go to the Congress in full force, and that the part they and their opponents take in the discussion of the question as raised by Mr. Hart may result in the adoption of a code under which all who love and practice regular medicine in America may work in harmony.

If Mr. Hart can bring about this state of affairs he will make the Congress a success, and win the lasting gratitude of the profession of America. In any event he has our best thanks for giving the profession, now so unhappily divided, an opportunity to reconsider this angry question of a dozen years ago.

We trust that our readers will not fail to attend the Congress in liberal number. Some important facts which add to the interest of the event may be found in the following letter from the Secretary-General. Dr. Reed says:

The scientific success of the meeting is now assured. The times are so hard that our attendance from the United States will probably not be as large as it would otherwise have been. This makes it all the more important

that those gentlemen who have accepted official connection with the Congress shall make it a point to attend. If they all come, or even a large proportion of them, we shall have numerically a very successful Congress. All of the countries, practically, have appointed official delegates in response to the invitation from the President of the United States, who will open the Congress in person. A large number of the Colonies and a great many of the Municipalities have also appointed delegates, as have the medical organizations throughout Latin-America.

The Governors of nearly all the States of the Union have appointed delegates to represent the sanitary interests of their respective States. These latter number nearly three hundred in the aggregate. It will be seen from this that special interest is centering in the Sections on Marine Hygiene and Quarantine, and on Hygiene, Climatology, and Demography, in charge respectively of Surgeon-General Wyman, of the Marine Hospital Service, and Medical Director A. L. Gihon, of the U. S. Navy. The imminence of cholera in the East, and the perennial prevalence of yellow fever in the South, give particular importance to the proceedings of these Sections at this particular time.

Notes and Queries.

THE NEW MEDICAL PRACTICE ACT.—The new law regulating the practice of medicine in this State will go into effect on the 3d day of October, next. By its terms it repeals all the old laws relating to this subject, and annuls all endorsements and registrations made under them, and requires that every physician now engaged, or who may hereafter desire to engage, in the practice of medicine, shall obtain a license from the State Board of Health, and have it registered in the county in which he resides. This applies equally to all graduates, whether from medical schools located in Kentucky or elsewhere, as well as to those who are exempted from obtaining diplomas because reputably and honorably engaged in practice in this State prior to February 23, 1864.

As no physician can legally practice without this license the Board has arranged to begin to issue them, to proper applicants, from this date, in order that all may have ample opportunity to register before the law goes operation. With his diploma, or evidence as to exemption from obtaining same, each applicant will be required to send his age, post-office address, place of birth, total number of years engaged in practice, years of practice in Kentucky, the school or system of medicine to which he professes to belong, and the license fee of two dollars, fixed by the law. Applicants whose diplomas were indorsed under the old law may save themselves the

trouble and expense of forwarding their diplomas again by giving the date of former indorsements, but in all other cases the diplomas or other documents upon which licenses are claimed must be sent to this office. These may be sent by express, prepaid, or by mail, with stamps enclosed for return.

Where the professional standing of the applicant is not known he will be required to obtain a recommendation from the Referee of this Board in his county, stating that he is a *bona fide* resident of such county and a reputable physician. As each of these requirements will be rigidly adhered to, applicants will be saved needless delay and correspondence by meeting them at the outset. The Referee for Jefferson County is Dr. W. H. Wathen for the regular profession, and Dr. Chester A. Mayer for the homeopathic profession, and similar appointments have been made in every county in the State, and it is suggested that all applicants from a county forward their diplomas or other credentials through their referee by express in one package. Blank forms may be had from him or the county clerk. For the convenience of the profession in Louisville the Secretary will spend two days in that city in the near future, so that certificates may be obtained direct by applicants whose standing is known to him, or who are properly recommended.

The General Assembly appears to have required this new registration under more stringent regulations, because, on account of defects in the old law, carelessness of the county clerks, mistakes in this office, and otherwise, many improper registrations had been made which could not be corrected in any other way. Every effort will be made to guard these points in administering the new law, and it is confidently believed that the protection thus secured to our people will many times compensate for the trouble and expense to the profession. The labor and expense involved in the administration of the old law was done gratuitously until recently, but it is believed that the profession neither expects nor desires that this shall be repeated.

By order of the Board.

BOWLING GREEN, KY., July 12, 1893.

J. N. McCORMACK, M. D.

Sec'y State Board of Health.

[The full text of the new law appeared in the *American Practitioner and News*, May 20, 1893.]

Special Notices.

"ROBINSON'S LIME JUICE AND PEPSIN" is an excellent remedy in the gastric derangements particularly prevalent at this season. It is superior as a digestive agent to many other similar goods. (See page —, this issue.) See remarks on their Arom. Fluid Pepsin also.

HYSTERIA:

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| R | Tinct. Castorei, | ½ oz.; |
| | Tinct. Valerian, | 1 ½ oz.; |
| | Aletris Cordial (Rio), | 6 oz. |
| M. | Sig: Teaspoonful four times daily. | |

THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNĀ."

VOL. XVI.

LOUISVILLE, KY., AUGUST 26, 1893.

NO. 4.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

THE ETIOLOGY AND PATHOLOGY OF INTRA - PELVIC INFLAMMATION IN WOMEN, ILLUSTRATED BY SPECIMENS AND CASES.*

BY L. S. M'MURTRY, M. D.

Professor of Diseases of Women, Hospital Medical College.

Intra-pelvic inflammations, with complications and sequelæ, compose the largest class of all the diseases of the pelvic organs in women. The pathology of this condition until recently rested upon a purely hypothetical basis, and in consequence was erroneous and misleading. Bernutz and Goupil thirty years ago, after careful clinical and *post-mortem* investigations, clearly set forth the true pathology of pelvic inflammations. The memoirs of these masters of the French school of gynecology were translated into English, and published under the editorial care of Alfred Meadows in London, and were reviewed at length by Parvin in this country, but the profession deliberately turned away from the truth and refused to accept it, preferring to adopt an altogether mythical pathology.

All the acute inflammatory diseases were classed under the general term of cellulitis, and no accurate knowledge existed as to the cause of the pathological process or the lesions. When operative surgery opened up the peritoneum to daily observation all these errors were dissipated, and a correct knowledge of the lesions was established. It is now known that pelvic cellulitis as a primary disease does not exist, and

*Read before the Kentucky State Medical Society, at Frankfort. May, 1893.

that so-called idiopathic peritonitis is a term to which no intra-peritoneal inflammation corresponds, and is misleading both as to pathology and treatment.

The pelvic inflammations, formerly so obscure, are now simplified so as to be clearly understood. If the causes of pelvic inflammation be thoroughly appreciated, there need be no difficulty in separating cases of real and apparent disease. The following essential points in the etiology and pathology of pelvic inflammations are established and can be demonstrated:

1. The lesions of pelvic inflammations have their focus and point of departure in the uterine appendages, especially the fallopian tubes, and involve varying areas of peritoneum.

2. These lesions are the result of infection, and the infection is almost invariably from without. Indeed the exceptions to this are so rare that the rule may practically be regarded invariable.

The mode of infection, as well as its exact character, varies, and I shall endeavor to describe these several modes of access as they appear in a rather extensive clinical experience.

The infection may be of puerperal origin, an infection of mild or severe grade during labor, and the puerperium may be the origin of an inflammation which presents its most serious lesions in the form of tubo-ovarian disease and recurring peritonitis with adhesions months and even years afterward. The infection may come from disregard of aseptic methods during labor. Excessive douching immediately after labor and during convalescence, with excessively strong chemical solutions, may be the means of infection.

Infection is very common after abortion or miscarriage. The placenta is not mature and ripe for detachment by contraction, and is readily retained, thereby favoring septic processes. Continued bleeding is another factor conducing to septic infection in this condition.

Gonorrhea is one of the most common causes of pelvic inflammations in women. The virus is so active and poisonous, and the channels of infection so direct and patulous, that the infection is readily conveyed to the endometrium and fallopian tubes, rapidly matting together the broad ligament and contiguous structures, and forming large sacs of poisonous pus. It must be remembered that the lymphatic channels about the cervix uteri convey infectious material to the peritoneum independently of the common method of continuity of mucous surfaces.

To these, which I will call natural causes, must be added the strictly artificial causes. There can be no doubt that the simplest procedures may, under certain circumstances, beget most serious lesions. The vaginal douche, for example, which is of inestimable value in treating pelvic congestions, may, if used with too great force or at the menstrual periods, start an inflammatory process, to end in inflammation of the tubes, ovaries, and peritoneum. Also the uterine sound, if unclean, may transmit an infection, and in certain rare cases may by its very presence produce severe pain, a chill, fever, and inflammation. How such simple interference with the interior of the uterus may be the cause of such serious mischief is as inexplicable as is the disturbance sometimes following the introduction of a sound into the male urethra.

The severe grades of tubo-ovarian inflammation and peritonitis following intra-uterine applications and operations upon the cervix are so common that these prolific causes of pelvic inflammation are becoming very generally recognized. The application of caustics to the endometrium and cervix, as is so commonly done to stimulate repair and change the nature of lesions too often misinterpreted, together with astringents and other agents, produce necrosis of tissue and infection along the patulous peritoneal channels.

One of the most common causes of pelvic inflammation is the operation of divulsion and dilatation of the cervix. This is usually done for the relief of dysmenorrhea from fancied stenosis of the cervix. It is an operation so mischievous in its results, and so seldom necessary, that it would be best if it were entirely banished from gynecological practice. Dilatation with sponge and laminaria tents is invariably followed by varying grades of salpingitis and peritonitis, and divulsion of the cervix by powerful steel instruments produces laceration of the cervix in the midst of lymphatic channels leading directly to the peritoneum. The results of this operation are never satisfactory as to permanent relief of dysmenorrhea and reflex disturbances, and its mischievous results far counterbalance any good it can accomplish. Any one who sees much of pelvic diseases can constantly trace tubo-ovarian inflammation and associated pelvic peritonitis directly to the traumatism and subsequent infection of forcible dilatation of the cervix. Excessive venery may cause lesions ending in pelvic inflammation.

In young women the accidents and disturbances of menstruation may produce intra-pelvic inflammations, terminating in adhesions, or may be going on to suppuration. During the past few weeks I oper-

ated in the case of a pure and refined young lady of twenty, in which an immense pyosalpinx and ovarian abscess had its start apparently in an inflammation due to exposure during menstruation.

There are certain systemic diseases, such as tuberculosis and syphilis, which may by localized lesions cause pelvic inflammation. The following photograph (Figure 1), made from a specimen which I recently removed by abdominal section in a case of pelvic inflammation of long standing, illustrates the lesions of a severe grade of pelvic inflammation advanced to the stage of suppuration. The patient is twenty-six years of age; had been married one year. The disease had existed several years prior to marriage, and had its origin in an infection by menstrual disorder of some kind. The uterus and its appendages were matted together and to adjacent structures by inflammatory exudate. The ovaries are cystic, and the fallopian tubes are filled with pus. Thorough enucleation and removal constitute the only rational treatment of such cases. This specimen illustrates long standing salpingitis and peritonitis, associated with cystic degeneration of the ovaries. The fallopian tubes are filled with thick, cheesy matter, the fluid elements having been absorbed.

The following specimen illustrates the most severe grade of pelvic inflammation. The disease had its origin in forcible dilatation of the cervix, and progressed rapidly to suppuration. As in the previous case, the inflammatory lesions are associated with cystic degeneration. The suppuration of tube and ovary on one side formed an immense sac of pus, which ruptured into the peritoneum. (Figure 2.)

The following specimen was removed a few weeks since in the midst of an active peritonitis. The tubal inflammation had its origin in an infection during the puerperal period, which was followed by recurring attacks of peritonitis. The fallopian tubes on each side contain pus, and all the pelvic organs were matted together by adhesive peritonitis. (Specimen exhibited.)

In conclusion I desire to record a case which, so far as my knowledge goes, is without parallel, and presents features interesting and unique: Mrs. R., aged thirty-two, married, the mother of four children, suffered with an attack of puerperal peritonitis during her last confinement, fifteen months ago. After a time she got up, but was not well. Being a young, energetic, and industrious woman, she persisted in giving attention to her household duties, and did not seek treatment. On the 26th of December, 1892, she went sleigh-riding with her husband



FIG. 1.

Double Pyosalpinx and Cystic Ovaries.



FIG. 2.

Parovarian Cyst.

Pyosalpinx and Ovarian Abscess.

and children, and, returning home, leaped from the sleigh to the ground. She was at once seized with violent pain in the abdomen, was cold and faint, and had to be carried into the house. She was put to bed, and the family physician, Dr. H. E. Pelle, was summoned. The doctor found her shocked and suffering, and administered stimulants and morphia hypodermically. She rallied, but developed an acute and diffuse pelvic peritonitis. I saw the patient with Dr. Pelle on New Year's day, and found her condition most serious. The pulse was 140, the temperature 104.6° F., the cheeks flushed, and entire surface wet with perspiration; the abdomen swollen and tender, limbs drawn up, and features pinched. I found the pelvis packed with inflammatory products, all the pelvic contents fixed by inflammatory exudate. The daily use of the catheter had been required for seven days, and so severe was the intra-pelvic pressure that a metal catheter alone would serve to empty the bladder. The patient was quickly transported to the infirmary, and preparations made for immediate operation. Dr. Pelle took the temperature in the mouth with a reliable thermometer just before she went on the table, and found the temperature subnormal. The pulse was small and feeble. Ether was administered by Dr. J. W. Guest. Dr. W. R. Kirk assisted, and Dr. Pelle was present throughout the operation.

On opening the abdomen the adhesions were found universal, and the omentum was fixed as a roof across the pelvis. On the left side pus was abundant in the peritoneum, and ran freely out the incision as soon as adhesions were broken up. In stripping away the ruptured abscess sac (fallopian tube, ovary, and broad ligament) from the sigmoid flexure of the colon an opening was made in the gut. Fecal gas was apparent by the odor coming up through the abdominal incision. In separating the suppurating mass upon the opposite side (tube, ovary, and broad ligament) great difficulty was encountered. The adhesions were old and organized. In accomplishing this, although not using extreme force, an active hemorrhage was started, and realizing the danger from shock I proceeded with all possible expedition. In turning out the mass I was amazed to find the body of the uterus come away with the mass, and I was confronted with an alarming hemorrhage. I quickly seized the cervix uteri at the floor of the pelvis with a large Spencer Wells' clamp, and at once arrested the bleeding. At this time the patient was pulseless. I proceeded quickly to irrigate the peritoneum with warm water, packed the pelvis down to the point of injured

gut with iodoform gauze, left the abdominal incision open with the clamp protruding, and hurried the patient to bed. Digitalin and strychnia were administered hypodermically, also brandy and nitro-glycerine. The heart was acting, but no pulse could be detected in the temporal or radial arteries for almost an hour. The circulation was gradually restored. The clamp was removed at the end of forty-eight hours, as was also the gauze packing. The patient had a large fecal fistula for eight days, great quantities of fecal matter pouring out of the incision. This gradually closed, and ceased to discharge altogether on the eleventh day. The edges of the incision granulated, and were approximated by adhesive plaster. The wound healed perfectly, and the patient's convalescence after the fourth day was quite easy. She returned home quite well at the end of six weeks, and is now, four months afterward, in perfect health, discharging all her domestic duties as formerly.

The specimen removed was carefully examined by all the physicians present, and the dissection demonstrated beyond question that the body of the uterus was in a sphacelated condition and came away with the mass of disintegrated structures. This case is unique, inasmuch as I have never known or heard of one like it. The history and initial symptoms led both Dr. Pelle and myself to expect to find the lesions of ruptured tubal pregnancy. The recovery from such extreme condition should encourage the careful completion of operations in such cases, even though the pulse becomes extinct at the surface. This case illustrates the most extreme ravages of pelvic inflammation.

LOUISVILLE.

REPORT ON NASAL SURGERY, WITH ILLUSTRATED CASES.*

BY M. F. COOMES, A. M., M. D.

Professor of Physiology, Ophthalmology, Rhinology, and Otology in the Kentucky School of Medicine, Louisville, Ky.

The status of nasal surgery compares favorably with other branches of surgical science, and its devotees will be found in the front rank of the army of surgical workers.

An inquiry into the causes of inflammations of the nasal mucous membrane, aside from those that are produced by syphilis and the exanthems, and a more careful study of the pathology of these inflamma-

*Read before the Kentucky State Medical Society at Frankfort, May, 1893.

tions has brought to light many things to guide us in their management that in years gone by gave both doctor and patient an incalculable amount of trouble. Many cases that were then considered catarrhal inflammations are now known to be due to malformations by which the membranes covering the septum and that covering the turbinated bones are thrown together, and thereby keeping up a constant irritation by their actual contact, and by preventing nasal respiration, or, more strictly speaking, by producing complete or partial nasal stenosis. Again, the erectile tissue that is found in the nose is often the seat of disease, and from one cause or another is kept in a state of constant erection which in most cases results in partial or complete stenosis, possibly all of the time in some cases.

In many the stenosis is of a temporary character, coming on when in a close room, or at night while in bed, or during the time of disrobing for bed. In such cases there may or may not be hypertrophy of the membrane. It exists in many to a limited degree. In some the membrane covering the inferior or middle turbinated bones is much thickened. The nasal secretion from most of these cases is composed almost entirely of a glairy, white mucus, which is at times streaked with blood when the nose is blown violently. As a rule there is no pus in the secretion, unless the patient should have an acute coryza. Washes, lotions, snuffs, and salves in such cases are only palliative. The remedy is to remove the hypertrophied tissue where the thickening is great, or by searing the surface from time to time with a hot wire from an electro-cautery in case the erectile is the seat of the trouble.

As a rule it is not desirable to destroy a great amount of tissue at one point of the nasal mucous membrane, because it results in a cicatrix, which will always be a source of annoyance because it affords a lodging place for inspissated secretions. Indeed, I have seen much harm result from too liberal use of the cautery in the nose.

The absence of pain during the process of the operation is no doubt the cause of this excessive burning. As the patient enters no complaint, the operator becomes unmindful of the fact that the hot wire is melting away tissue that ought not to be destroyed. Young operators are very liable to overlook this important point in the use of the cautery.

The greatest benefit in most cases is in simply searing the surface from time to time until the terminal ends of the sensitive nerves become so obtunded as to prevent them from responding to every insignificant irritant that comes in contact with the nasal mucous mem-

brane. The quieting of these irritable nerve-endings enables the membrane to assume its normal condition, and finally enough rest results in a cure.

The following case is an interesting one, as it shows to what degree this nasal irritation may make an individual unhappy: Mrs. H., aged twenty-four, apparently in good health, complained of restlessness and an inability to procure good, sound sleep. She had an attack of diphtheria some eighteen months preceding last March, the time at which she consulted me concerning her difficulty in breathing, and also the defect in her voice, which amounted to an inability to pronounce her *m*'s and *n*'s plainly, always failing to sound these two letters as they should be in certain words, as in *money* and *common*.

During her sleep she tossed about the bed, the muscles of the extremities acting frequently as though they had been irritated by an electric current, the legs and arms being suddenly flexed and then relaxed. She had complained of this a year prior to this last visit, and at that time I ordered her to take strychnia, which was kept up for five months save at short intervals. The effects of the strychnia were not manifest so far as the choreic symptoms were concerned, for they were much the same at the end of the five months as in the beginning, and she ceased the use of the strychnia, as she said, "because it did not prevent the muscular twitchings."

At her visit in March she asked me particularly about the possibility of the nasal tone which she had being caused by a form of diphtheritic paralysis which she had learned might produce such results, and also thought that the difficult nasal breathing might be due to the same cause. A critical examination revealed the fact that the membrane covering the inferior turbinated bones was much thickened and very sensitive to the touch. The surface was cocaineized and the free border seared from one end to the other. This maneuver was gone through with about every eighth day until it was repeated six times. After the third burning the muscular twitchings ceased, and up to date she has been free from them. Her voice and breathing were fully restored to their normal condition at the time of dismissal.

This case is given for what it is worth, going to show as it does that the cause of disease is often remote from the symptoms manifested.

Removal of nasal tumors is much the same as it was in years gone by, viz., by surgical means. The great difference consists in the means at our disposal for this purpose, the most valuable of which is cocaine.

With it we are enabled to accomplish many things now that before the era of cocaine would have been impossible, because of the great pain accompanying such operations without an anesthetic for such purposes. Another objection to general anesthesia in such operations is because of the blood, which in many instances gives rise to no small difficulty during such surgical procedures.

With the aid of cocaine the cautery wire may be used on children of tender years, and tumors removed from the same class of patients with little or no difficulty, whereas without it such operations on the nose would be impossible and impracticable without general anesthesia. There have been many improvements in the instruments used for removing tumors from the nose, and particularly in snares, hooks, and scissors is this advance most marked.

The implements that have been devised in the last ten years for dealing with bony structures are numerous and valuable. Probably the most valuable are to be found in the saws, bone pliers, and pliers for breaking the bony septum.

CORRECTION OF NASAL DEFORMITIES, AND RESTORATION OF THE NOSE WHERE IT HAS BEEN DEPRESSED AS THE RESULT OF INJURY OR DISEASE. The nose being an organ made up largely of muscles, skin, and mucous membrane, which is richly endowed with blood-vessels and nerves, is a field that is well calculated for plastic work.

It is well known to every one that the nose will stand almost any amount of mutilation, and in some cases it would seem almost impossible to destroy this organ by any fair means, so persistently does it hold its own under the most adverse circumstances. With this knowledge of the anatomy and peculiarities of the structures entering into the composition of the nose, the surgeon is armed with a weapon to battle with any foe that he may encounter in this region—the face or the nose. The work of restoring a depressed nose is in most cases plastic, and requires that the surgeon should at least be an expert surveyor and a ready deviser, as it often happens that his plans, which have been made previous to the time of actual work, will have to be changed after the work has commenced, and unless the surgeon is prepared to make any change that may be needed in the work during its progress he will certainly be much embarrassed and his patient liable to suffer from want of such skill.

The following cases, with the accompanying cuts, will serve to illustrate what can be done with a nose :

CASE I. Edward Peters, white, aged twenty years, a native of Depauw, Indiana, was sent to me by Dr. George W. Baylor, of Milltown, Indiana. Mr. Peters is a well-developed man, of muscular frame, and in every way perfectly developed, save the nose, as shown in Figure 1. During the time that Mr. Peters' mother was pregnant with him she became very much frightened at a mad sow, and when Mr. Peters was born his face was disfigured by the nose being shaped in many respects like that of an ordinary "hog snout." Particularly is this manifest in the nostrils, which, as will be seen, stand wide open. There is no other defect of body or mind. Mr. Peters is well educated, and a man above the average in intelligence. Without entering into any discussion as to whether the fright received by the mother had any thing to do with producing the malformation of the child, I will proceed to tell how I corrected the deformity.

Mr. Peters was very anxious to have the nose put into passable shape if possible, and with that view gave me full and complete charge of his case, with permission to continue to operate until both he and I should be satisfied with the results. It was an unusual operation, and one of greater magnitude than it would appear to be at first sight. I searched in vain for something in the works on surgery to enlighten me concerning the operation, and finally had to plan an original operation for the case. With every thing ready, and with Professor Henry Orendorf as the anesthetizer, ether being used, and Drs. G. W. Baylor, Samuel Holloway, and John H. Metcalfe, of Louisville, the operation was proceeded with as follows:

An incision was made from a point where the nasal bones and the cartilages unite, downward through the median line to a point on the lip where the nose or proboscis terminated. Then two lateral incisions were made extending horizontally almost to the nostrils, care being taken not to encroach upon the mucous surface. Then all of the tissues were dissected up and pushed aside so as to fully expose the underlying osseous growth. This osseous growth was about the size of an ordinary walnut after the hull has been removed. It was round, and was really a double shell, the outer portions being as hard as ivory, and the inner portions being made up of bone tissue resembling cancellated osseous structure. The outer portions were extremely hard, so much so that I broke two good saws before I was through with the operation. In order to avoid mutilating the soft tissues, it was necessary to remove the mass of bone in sections. The first was a wedge-



FIG. 1.



FIG. 2.



FIG. 3.



FIG. 4.

shaped piece taken from the center; then pieces were removed from first one side and then the other until four other pieces were removed. Then the remaining portions were broken off with pliers and chiseled off until all of the bone was removed, at least as much as desired. There was not a great amount of bleeding, but it was troublesome on account of some of the vessels coming through the cancellated portions of the bone. After the bleeding had been thoroughly stopped, a stout ligature armed with an ordinary shirt button was passed through the nose from one nostril to the other, taking care to pull the left nostril into its proper position, it being the most out of place. Apposing the parts in such a way as I thought best, another button was placed on the ligature and pushed down into the right nostril, and retained in its place by a perforated shot. Two other ligatures were placed higher up, and retained in the same manner with buttons and shot. This was the major adjustment. Then the edges of the wound were carefully adjusted and closed with an ordinary silk over-stitch, and the wound covered with iodoform gauze. A small drainage-tube was placed in the most dependent part of the wound. Thorough asepsis was practiced during the operation, no antiseptic being used save the iodoform dressing. The patient was given an opiate and put to bed; had a fair night, but suffered some on the following day from nausea as the result of the etherization. The temperature was 100.5° the first day after the operation. On the second day in the afternoon the temperature was 102.5° . There was no pain, nor was there much swelling, no pus, nor any thing to indicate that the temperature was the result of the operation. Twenty grains of quinine were given during the evening, and on the following morning the temperature was 99° , and during the day went down to 98.5° , and there was no further rise.

The second operation was done on May 4th (the first having been done April 13th), under ether. This consisted in remodeling the soft tissues that were left after the first operation. As shown in Figure 1, the proboscis extended down onto the lip fully one half of its length. There was a good deal of the substructures that it was necessary to remove—that portion which extended down onto the lip was a sort of cartilaginous mass.

This second operation was done by laying the tissues open along the median vertical line down as far as the growth extended onto the lip. Then two lateral incisions (one right and one left) were made along the line where the upper end or edge of the lip ought to be.

This exposed all of the sub-tissues, and after removal of such of these structures as I deemed necessary, and after shaping the flaps so as to make them unite properly, they were closed with small silk sutures, and a dressing of iodoform gauze was placed over the wound and held in position by collodion. There was no rise of temperature after this operation, and union was perfect everywhere along the line of the wound, and there was no pus formed save at the site of the sutures. The stitches were removed on the third day, and Mr. Peters returned home on the eighth day after the second operation. The time intervening between the first and second operations was twenty-one days. Figures 1 and 2 represent his condition before and after the operation.

The case represented by Figures 3 and 4 is that of Mr. Hermann Bouroughs, of Morganfield, Ky. Four years ago he was run over by a wagon, and the outer plate of the frontal bone, nose and face were badly mashed, the nose being so crushed as to force it down to a common level with the adjacent parts of the face. His injury was so severe that his parents and physicians thought that recovery was impossible, and as a result little attention was paid to his nose. The inner canthus of the left eye was pulled down much below its normal position, and a large cicatrix existed just below the left eye at the junction of the nose and the face.

Examination showed that one of the nasal bones had been lost, either by absorption or had come away at the time of the injury. The other was flat down and in such a position that I deemed it best to let it remain where it was, as the operation was to be done only for cosmetic purposes, his breathing capacity through the nose being good. This operation was done April 4, 1893, by making an incision from a point a little above where the eyebrows unite down almost to the tip of the nose, carrying the cut down cleverly through the true skin and immediate underlying tissues, which were dissected up well down to the face—that is, well down to the line where the tissues curve up from the face onto the nose. The cicatrix under the left eye was cut in such a manner as to let it loose from its holdings, and thus enable me to elevate the canthus on that side. After a thorough dissection of all the tissues that were desirable the parts were pulled together and elevated so as to give the nose more prominence than would be desirable under ordinary circumstances. This was done to allow for contractions, which always follow such operations to a certain extent. The apposition of the parts was maintained by two small rubber splints,

one placed on either side of the nose in such a position as to keep the structures in the desired position, and they were kept in their places by passing three ligatures through the splints and all of the intervening tissues. The ligatures were kept in place by shot. These splints gave a firm support, and the wound was then closed with small silk sutures, eight or nine in number, so as to bring the integument into perfect apposition. The wound was dressed with iodoform gauze. No elevation of temperature of any consequence followed the operation. There was no pus, not even stitch suppuration. The result of the first operation was most gratifying, almost giving the results desired. Near the lower part of the wound the cicatrization was greater than I anticipated, and on the fourteenth day after the first operation a small incision was made near the lower part of the former wound, and in the same line, and the parts lifted up and kept in place by the use of two common shirt-buttons, one being placed on the ligature before it was passed through, and the other after it had been passed. A shot followed the last button, and when every thing was perfectly adjusted the shot was made to clamp the ligature and keep it in place. This last operation completed the result, as seen in Figure 4.

These two operations illustrate the kind of work that can be done about the face, and I trust will be of some benefit to the profession, who will find, as I did, that there is but little written in books or journals upon this very important branch of surgery.

LOUISVILLE.

SOME HEREDITARY AND CONGENITAL EYE DISEASES.*

BY J. MORRISON RAY, M. D.

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The trend of modern pathology is to a study of the bacterial origin of disease. This has probably been carried so far that other important aids to diagnosis have been neglected. Our forefathers in medicine laid great stress upon temperament, diathesis, and idiosyncrasy in diagnosis and prognosis. Other things besides the mere presence of an organism certainly play an important part in the development as well as in the propagation of disease. This is nowhere better illustrated than in the ravages of tuberculosis in certain families.

*Read at the May Meeting of the Kentucky State Medical Association, 1893.

Mr. Jonathan Hutchinson, in his interesting lectures on the Pedigree of Disease, emphasizes the importance of the study of family histories and predisposition, and gives a number of most interesting and graphic examples showing beyond doubt the proneness of certain forms of inflammatory disease to be transmitted.

Older writers placed such great confidence in this manner of diagnosis that Mr. Hutchinson says Prof. Laycock was, by a study of the temperament and physiognomy of his patients, enabled to make diagnoses that astonished his associates. The question of hereditary and congenital diseases must therefore at all times interest the physician.

In the study of the eye we often encounter certain congenital defects that plainly have been transmitted from parent to offspring. Less frequently we see diseases developing in adult life that show distinctly the results of a hereditary predisposition. But little space is given in our modern text-books of ophthalmology to the study of this class of diseases, seemingly preferring to emphasize the inflammatory forms of disease wherein can be found some form of micro-organism on which to base the pathology and treatment. While probably diseases due to an inherited weakness are less frequent and less amenable to treatment they demand attention. Under existing social conditions we may have but little effect in preventing them. Then it is well that they be recognized, and the possibility of their development understood.

Many varieties of eye diseases appear as the result of a hereditary transmission. Deformities of certain kinds are known by their appearance to be congenital.

I do not propose to enumerate all the possible anomalies that may occur as a result of a predisposition, but to call attention to a few eye disorders that have come within my personal observation wherein this tendency was well shown.

That like begets like is nowhere better demonstrated than in the study of refraction of the human eye. Hypermetropic and astigmatic parents beget hyperopic and astigmatic children, myopic parents, children with a tendency to myopia. This rule is so constant that one can often predict with certainty the condition present before an examination, the family history being known. This statement was impressed upon me by the study of a family that have been under my observation for six years.

In the spring of 1888 I operated on the eyes of Mr. Y., aged seventy-one years, for cataract. I operated upon the right eye first. Before

operating an examination showed good light perception throughout the extent of the visual field. The operation was a success from a surgical standpoint, yet when I tried to adapt lenses to compensate for the lens removed I was only able to get vision equal to 20-200, with the combination as follows: $+12.D^s = +2.D^c \text{ ax } 120$. The left eye was then subjected to an operation six weeks afterward with $+11.D^s = 1D^c \text{ ax } 180$. Vision was 20-40. Eventually this became 20-30 with spherical $+11.D$. The right eye never improved. On questioning I could find no evidence of the right eye being defective before the formation of the cataract. Since that time I have examined on different occasions four of Mr. Y.'s children, all daughters, and they all present one amblyopic and astigmatic eye, showing the transmission of the defect that had been present in his eye before the development of the cataract. A study of the family of these daughters is also interesting. The oldest, Mrs. P., has with the right eye only 20-100 vision when the best correction is made. This consists of $+2.D^s = +1.75$, $D^c \text{ ax } 135$. The left has with $+2.D^s$ vision equal 20-20. Mrs. P. has two children, both of whom have a defective eye. The son has this defect: $R + 2.75 D^s = 20-40$, $L + 2.75 D^s = 2.D^c + 45 = 20-70$. The daughter is amblyopic in right eye, and with the best correction, which is $+2.50$, $D^c \text{ ax } 120$ —the sight, is only made 20-100. Mrs. J., another of Mr. Y.'s daughters, is amblyopic and astigmatic in one eye, and she has two children, both of whom I have fitted with hyperopic and astigmatic lenses. A third daughter of Mr. Y., now single, is amblyopic and astigmatic to a decided degree. The fourth daughter I have treated for a conjunctival inflammation, and she, while having defective sight, refused to wear glasses.

Myopia probably presents the strongest evidences of inheritance of any of the forms of refractive defects. Numerous examinations of the eyes of the newly-born prove conclusively that children are not born myopic.

My friend the late Dr. E. T. Ely was among the first to point this out. We have, however, abundant evidence to show that the children of myopic parents present strong inclination to eventually develop this defect.

Among my personal observations is the family of Mrs. G. She has a myopia of 8.D, with divergent squint and amblyopia in the left eye. Her husband I have never examined, yet I understand he is near-sighted. I have examined four of her children. One, aged nineteen, a young lady, is wearing 12.D, each eye fitted by a prominent ophthal-

mologist in another city. With these her vision is only 20-100. Second child, aged seventeen, wears 7.D each eye, adjusted by myself. Third child, aged eleven, has myopia 6.D in the right eye; myopia, divergent squint, and amblyopia in the left eye. The fourth child, aged eight, has myopia of 4.D, but does not wear glasses.

Mr. Nettleship, in an article in the Royal London Ophthalmic Hospital Reports for 1887, presents a number of cases, and traces the family histories, several of them showing how amblyopia, combined with refractive and other defects, tends to show itself to such a decided extent as the result of inheritance.

Strabismus frequently follows from parent to child. I can recall three families in which I have operated upon two or more for convergent squint, and one in which the mother and two daughters suffer from this defect.

A friend has reported to me a family of six children, five of whom have crossed eyes.

Lang and Barrett, in a large number of investigations, found that twenty-nine per cent of cases of convergent squint gave a history of heredity. One remarkable instance was where for four generations two or more in each suffered from this defect.

Among the more serious eye diseases wherein heredity often becomes a most important etiological factor is cataract. Investigation sometimes in this disease often reveals a most interesting family tendency. This disposition is noted in all forms of cataract, whether infantile or senile. A few remarkable examples are found in literature. A Russian writer reports a family in which, out of forty members traced, nineteen suffered from congenital cataract.

Berry (Ophthalmic Review) reports a family which he was able to trace through seven generations. Out of fifty-nine members twenty suffered from cataract in early life.

Thompson (Transactions Royal Ophthalmological Society) investigated a family through five generations. Of twenty-eight, eleven were known to be affected.

An interesting family showing this tendency has recently been under my observation. The family Redmond I encountered while examining the pupils of the Kentucky Institution for the Education of the Blind by favor of the superintendent, Prof. B. B. Huntoon, the children found in the family all suffering probably from congenital cataract. They were aged respectively eighteen, sixteen, fourteen, eleven,

and nine. The four oldest were girls, the youngest a boy. I tried to get a complete history of this family, but only succeeded in finding that the father suffered in a similar manner, and that he had a brother with one child also affected. The five I have reported are his only children. These have been subjected to operation by absorption, with considerable improvement in all, yet, like all such cases, there is a congenital deficiency in the perceptive power of the retina.

The senile form of cataract less often shows such strong hereditary tendency as those just reported.

Roosa, in the American edition of Schmidt-Rimpler, says he has operated on three in the same family for the senile variety, and he knows of a family where there were five cases. I have extracted in one case recently whose mother had submitted to a similar operation at the hands of the late Prof. S. D. Gross when he was a resident of this State.

A study of glaucoma often shows a decided tendency to heredity. Harlen reports a case in a girl of seventeen years whose ancestry for four generations were known to suffer in a similar manner. Von Graefe was aware of this peculiarity in glaucoma. I have encountered a few instances showing this tendency. I have had under observation two sisters, both of whom were blind in one eye from acute inflammatory glaucoma, and the mother was said to have become blind when quite old, most probably from the same trouble. I have under treatment now a gentleman suffering from glaucoma in both eyes, one complicated by hemorrhages, whose father was blind for a number of years by an eye disease that gave rise to frequent attacks of neuralgia. I have also encountered one case in early life in which there was a family history of a similar defect in others of the family.

I might continue farther in the line of congenital eye diseases, and report cases showing structural changes of different varieties, also the results of eye disease due to condition of race; for instance, the proneness of the Jewish race to glaucoma and the colored race to so-called strumous eye disease, yet this would take me rather into a study of diathesis.

I have given these notes not so much for the purpose of putting on record the cases, but to emphasize the condition that often underlies many ophthalmic diseases, and to show that while investigating the etiology of disease it is often advantageous to lay aside modern bacterial investigation and search the family tendencies of the patient.

THE DIFFERENTIATION OF ACUTE BRONCHO-PNEUMONIA AND BRONCHITIS IN CHILDREN.*

BY HENRY E. TULEY, M. D.

In the writings of most of the older diagnosticians, and in many of the more recent ones, bronchitis and acute broncho-pneumonia have been confounded, but it is the belief of the writer that many cases of bronchitis so diagnosticated are in truth cases of acute broncho-pneumonia.

My attention to this point was first aroused while resident at the New York Infant Asylum during the service of Dr. L. Emmett Holt, and later by a comprehensive and thorough paper on this subject, by Dr. Holt, published in the Archives of Pediatrics in December, 1891.

The object of this short paper, for the facts of which I am indebted to the above-mentioned article, is to second Dr. Holt in his efforts, hoping to make plain the identity of many cases of bronchitis and acute broncho-pneumonia, especially that large class of cases termed "capillary bronchitis."

A glance at our city death-returns will show how prevalent among our medical brethren is the use of this term "capillary bronchitis."

It is evident without demonstration that it is impossible for an inflammation to occur in the smaller bronchi and their terminal branches, in an infant, without spreading to and involving the surrounding structures.

'Tis true that there are cases where it may be impossible, clinically, to make a differentiation, but I believe the number of such is small.

There is little or no difficulty in making out a bronchitis of the larger bronchi, both from the physical signs, the character of the râles, etc., and the general symptoms, absence of great prostration, little fever, etc. It is rare that we find a unilateral bronchitis.

The temperature in bronchitis is usually high during the first day—reaching its maximum then, 102° or 103°—which lasts twenty-four or thirty-six hours; a fall to 100° or normal then occurs, fluctuating for a degree or so for several days, with a subsidence coincident with the cessation of the local trouble.

There is little or no prostration and the symptoms of a severe lesion are absent.

But how different the clinical aspect of a broncho-pneumonia: Given a case with an initial temperature of 101°, or thereabouts, and the sub-

* Read before the Jefferson County (Ky.) Medical Society, June 6, 1893.

sequent history shows a rise on successive days to 102° or 103° , with the general symptoms, prostration, cyanosis, etc., present, we are sure of having a serious disease of the lung to deal with, though the physical signs may not present themselves until later.

As to the importance of a diagnosis in these cases, I quote from Dr. Holt's article :

"It may be urged that as there is no difference in the management of a case of severe bronchitis and one of broncho-pneumonia, a diagnosis is of no practical importance. This may be admitted from the standpoint of a therapist in the acute attack. It is, however, essential to a correct understanding of what so often follows such an attack—relapses, recurrences, or chronic pneumonia—to know from the beginning there existed not only a bronchitis but broncho-pneumonia."

Our diagnosis, then, is to be largely made up from the "severity of all the general symptoms, cough, prostration, restlessness, dyspnea, and cyanosis."

If the physical signs of pneumonia be present, bronchial breathing, dullness, etc., there is no doubt about the diagnosis; but I have often seen cases in which at the autopsy disseminated patches of broncho-pneumonia were found, but in which there had not been present dullness on bronchial breathing at careful physical examinations made before death.

The temperature in broncho-pneumonia is variable, no typical courses being followed. In the majority of cases it is high and remittent, in others it is 103° and below, but it is not infrequent that we have temperatures running below 101° , sometimes even sub-normal; the latter occurring more frequently in children who are very delicate than among those of robust condition. There is generally a morning remission and an evening exacerbation, but it is not unusual to meet with the opposite condition, a higher morning temperature, lasting for several days, the resulting chart being very characteristic. The temperature may reach as high as 107° or 108° , and is generally fatal. The highest temperature recorded in Dr. Holt's series of cases with recovery was 106° of twenty cases, seventy-five per cent proving fatal.

The duration of the temperature is, of course, very varied. Cases are reported as lasting from a few days to fifty-one days or more, the greatest mortality in the cases above referred to being one hundred per cent in those cases lasting four days or less.

Of the physical signs which we may expect in pneumonia, are dull-

ness, bronchial breathing, or change in the respiratory note, râles, and pleuritic friction sounds.

The absence of dullness and bronchial breathing, as before stated, does not by any means preclude the presence of pneumonia; the patches of consolidation may be so disseminated, with normal pulmonary tissue intermixed, as to cause no deviation from the normal pulmonary resonance or change in the respiratory note, except perhaps a slight weakening of the latter. Time and again I have seen cases throughout have no dullness, on superficial or deep percussion, with the other pathognomonic signs of pneumonia present.

The presence and the character of the râles, and particularly their location, is of importance. Finding a localized area of râles, either on one or both sides, should cause pneumonia to be suspected, especially if over one or both lower lobes behind.

Of pleuritic sounds, Dr. Holt says: "They may be looked for in broncho-pneumonia whenever we have large areas of consolidation present, but in my experience, based upon *post-mortem* investigation, and it has not been small, almost never under other circumstances. In the cases under discussion they are so rarely heard that they may then be dropped from our thought altogether."

The general aspect of the child when afflicted with pneumonia is characteristic; the prostration is generally severe, the cyanosis more or less marked, dilatation of the alæ nasi present, increase in the pulse and respiration in the proper ratio, and we nearly always hear the "pneumonic sigh" caused by the short, sharp expiration.

It is the combination of these general symptoms which in the absence of pathognomonic signs would cause us to class these cases as broncho-pneumonia, and not "capillary bronchitis," especially those cases which only give signs of generally distributed râles with few other definite signs. The diagnosis can well be verified by an autopsy, if it may come to that.

Broncho-pneumonia may always be considered a dangerous disease. The percentage of mortality has been variously stated. Holt gives it as sixty-eight per cent in his 156 cases recorded, while the mortality from acute bronchitis is practically *nil*.

In conclusion I would state that in the opinion of the writer the term capillary bronchitis can not properly be used, for pathologically, and in the great majority of cases clinically, these are cases of acute broncho-pneumonia and not "capillary bronchitis."

Reports of Societies.

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.*

Stated Meeting, May 12, 1893, Dr. F. C. Simpson, President, in the chair.

Dr. T. H. Stucky: In making my rounds at the City Hospital this afternoon I found this patient, and the case struck me as being one of considerable interest, especially as to the diagnosis, which seems to be very obscure. I will read the history as entered in the hospital record by Dr. Rousey, the Interne:

"J. R., residence, Louisville; occupation, baker; age, fifty years. Father dead, cause unknown; mother dead, old age. Number in family, five; health good. On or about April 1st was taken with vomiting, and pain in the epigastric and hypochondriac regions; bowels regular at this time, but since has had alternate diarrhea and constipation; stools yellowish brown, highly colored. For last three weeks has been worse, and noticed tumor in left hypochondriac and epigastric regions; suffered from insomnia, anorexia; coated, flabby tongue. Entered hospital May 10th; temperature 101.5° F., pulse 110; complained of headache and pain in abdomen. On examination found tumor, which could be easily outlined by palpation. When lying on back could easily detect pulsation synchronous with heart-beat; tumor movable, and gives apparent fluctuation; flatness on percussion; auscultation negative, unless lying on the back, then a transmitted bruit is given. Treatment, salines, with big enemas; bowels moved well, but not affecting the size or shape of the tumor."

This case seems to me to be of unusual interest. The tumor is very marked; was first noticed about six weeks ago, having grown very rapidly since. There is no history of jaundice.

Dr. A. M. Vance: I think there is an accumulation of fluid, either a cyst or abscess of the liver; I hardly think it the gall-bladder.

Dr. A. M. Cartledge: I think there can be no doubt about this being the gall-bladder distended with mucus, and probably a little bile. It has every evidence of this trouble, tense feeling, fluctuation, etc.; and besides it is pretty near the region of the gall-bladder, reaching up

nearly to the notch in the liver. Ten or twelve weeks ago I had a case which somewhat resembled this one, except that it did not have the appearance of being cystic, as this has. I made the diagnosis of distended gall-bladder, cut down upon it, and found it was a soft tumor of omentum. I took out a section of it, and diagnosis was made by the microscopist of sarcoma. The most remarkable feature about that case is that the man has steadily improved since the operation, has gained in flesh, and really looks as though he were going to get well. The wound closed without any trouble.

Dr. D. T. Smith: It seems to me that the tumor produced by a distended gall-bladder would not have so sharp a contour in that position. Again, the other evidences, such as obstructed flow of bile, etc., are not present. There was a case in the City Hospital some years ago, when I was in attendance there, in which I with some distinguished physicians made an examination, and every one of us missed the diagnosis. There was a tumor in the epigastric region, and it looked very much like the case before us to-night. Aspiration was practiced on one or two occasions. The man died a few days afterward, and the trouble turned out to be an abscess of the left lobe of the liver. I am rather inclined to that opinion in this case, although we know how liable we are to be mistaken in such a condition.

Dr. Dixon (visiting): The case is one of great interest to me. The tumor evidently seems connected with the liver in some way. I do not think it is the gall-bladder. I had a similar case in the person of a lady in our town, in which the tumor disappeared under purgative treatment and local application of iodine. The tumor reappeared the third time, and each time disappeared under purgation and local applications of iodine. I examined her under an anesthetic, and could trace the tumor up to the notch of the liver, and I am almost certain it was not the gall-bladder; neither do I think it was an abscess of the liver. In the case before us I think the trouble is probably abscess of the liver.

Dr. Stucky: I would like to have had some suggestions as to treatment of this case, whether it would be considered strictly surgical, whether it would be best to aspirate, perform a laparotomy at once, or further try the saline treatment. He was placed upon salines on the night of the 10th instant, which has produced no material change in the stools as to color or character. They have been a little more frequent and more watery. The question with me was, whether it is strictly a surgical or medical case.

Dr. J. B. Marvin: In regard to the trouble being in the gall-bladder, the point made by Dr. Dixon against that view I do not think is well taken. Not many years ago Dr. Larrabee had a case in a child having a large tumor in this region, which was tapped and reported as a case of abscess of the liver. I took issue at the time, and requested Dr. Larrabee to allow me to be present at the autopsy if the child died. In the process of time the child did die, and Dr. Larrabee and myself made the autopsy. We found over a quart of fluid in the gall-bladder. The cystic duct was obstructed, preventing the flow of bile into the duodenum. The absence of jaundice does not necessarily figure against the idea that the trouble in the case presented is in the gall-bladder. I am rather inclined to that view, that it is a distended gall-bladder rather than abscess. I have taken some little pains in looking up reports of abscess of the liver, and have never seen a case where there were not more marked extreme symptoms than this man has complained of.

Dr. Cartledge: I believe the only way to get at exactly what the trouble is in this case is by an exploration. In the first place I do not see how it can be retro-peritoneal trouble. In the next place it seems to be clearly cystic, and there is considerable distension. In the third place the history of the case, if it bears out any thing, is one of empyema of the gall-bladder. Jaundice does not play any part. This is the very kind of a case in which we have no jaundice necessarily. Probably a calculus has become obstructed in the cystic duct, and the gall-bladder is distended with bile and mucus. The gall-bladder might be distended in this way, and the functions of the liver not interfered with.

Stated Meeting, May 26, 1893, Dr. F. C. Simpson, President, in the chair.

Dr. Turner Anderson (Traumatic Aneurism): This young man, about two years ago, was handling a bar of iron when a piece was detached and penetrated his thigh. He was seen soon afterward by his physician; was little inconvenienced at the time, but soon noticed that there was a tumor on the inner side at about the middle third of the thigh, which has continued to enlarge. It is plainly a case of traumatic aneurism.

DISCUSSION.

Dr. A. M. Cartledge: It is certainly a very pretty illustration of traumatic aneurism. I would like to say that I think the best treat-

ment for this condition is direct dissection after tying above and below the point. I had occasion some months ago to see a very large traumatic aneurism in this locality, perhaps a little lower, developing fourteen years after a shot wound with a twenty-two caliber bullet. It was an enormous aneurism, occurring in the practice of Dr. Chenoweth, who operated upon it, making a direct dissection. The patient was a negro woman. She made an uninterrupted recovery, and is perfectly well to-day.

Dr. W. L. Rodman: I fully agree with what Dr. Cartledge says. It is evidently a circumscribed traumatic aneurism, and the treatment he suggests is the only treatment to be thought of.

Dr. A. M. Vance: I agree perfectly with what the two gentlemen have said.

Dr. F. C. Wilson: The diagnosis in this case is a very easy one. The thrill is very distinct, the expansive impulse plainly felt, and the bruit can be very readily heard. There is no question as to the vessel involved (femoral), and no doubt the treatment suggested by the surgeons is the one to be adopted. Of course the case naturally falls into the hands of the surgeon after the diagnosis has been made by the attending physician.

Dr. E. R. Palmer: The aneurism is splendidly located for collateral circulation, and I think the operation ought not to lay the man up for more than a few days. Collateral circulation would be established without any trouble whatever.

Dr. Rodman: I would say in answer to Dr. Palmer's question that the plan of digital compression was very largely followed at one time with excellent results in many cases. This treatment is more particularly applicable, however, to idiopathic than to traumatic aneurism. Then you have compression by means of different instruments, Reid's method, or compression by Esmarch's bandage, for instance, which is probably the best of all. In the traumatic variety I think the open treatment, dissecting out the aneurismal sac, is undoubtedly the best.

Dr. Cartledge (Cholecystotomy; Recovery): These specimens I removed twelve days ago to-day from a patient thirty-four years of age, female. Six weeks ago the patient, a robust, healthy subject, never having suffered from any thing, was taken with what was supposed to be a case of ordinary colic. Her physician was summoned, and after an examination he concluded that it was a case of indigestion, and gave

her a hypodermic injection of morphia, which relieved her. The following day was spent in comparative comfort, the patient going about attending to her household duties. On the following night there was a return of the pain, which she referred particularly to the epigastric region. The trouble was supposed to be with the stomach, and some commonplace remedies, cathartics, etc., were administered, but without any special relief. In four or five days, however, her physician noticed a small tumor situated a little to the right of the stomach in the region of the gall-bladder, and concluded that the trouble was in the gall-bladder itself, and was due to obstruction of the cystic duct. There was slight jaundice. The tumor when first noticed was very small, and continued to enlarge gradually. She had several attacks of pain, and some two weeks afterward the pain passed away, but the tumor remained, enlarging all the time. I saw the patient about this time, and agreed with the physician that it was a case of distended gall-bladder owing to obstruction of the cystic duct.

Twelve days ago she was subjected to an exploratory incision. The gall-bladder was found very tense; there were some slight adhesions of a very friable character to the surrounding structures, which we easily separated by the fingers; the gall-bladder was opened, and contents found to be mucus (not bile), and in the cystic duct were found the specimens I present. There were twenty-three calculi in all, five large and eighteen smaller ones. They were carefully removed, and the gall-bladder stitched to the abdominal wall and peritoneum excluding skin. In the case of cholecystotomy which I reported to this Society some months ago I stitched the gall-bladder, carrying the sutures through the skin, muscular coat, and parietal peritoneum. This case did uninterruptedly well, but at the same time there was some little drawing sensation, which I thought could be easily avoided by leaving the skin out of deep sutures. The subsequent course of the case reported to-night was without an accident; there was no pain, no elevation of temperature, and not a drop of pus. The wound has closed with the exception of a very small fistula, and the patient is up and went down to dinner to-day (twelfth day after the operation). What I wanted to call especial attention to was the manner of stitching the gall-bladder, not carrying the stitches beneath the skin. I think this method of great advantage, because when the stitches are carried through the skin it usually gives rise to stitch abscess and pain. Drs. Vance, Chenoweth, and Scott assisted in the operation.

DISCUSSION.

Dr. Vance: I saw the patient referred to in consultation with Drs. Cartledge and Scott, and feel that Dr. Cartledge ought to be congratulated upon the rapid and excellent result obtained. I think the question in these cases, in the mind of the surgeon, is whether he has removed all the calculi or not. I feel sure they were all gotten out in this case, though for three or four days there was no discharge of bile. I think this is occasioned by the fact that there is infiltration about the duct, or irritation due to a certain amount of injury done in the effort to remove the stone from the duct, which causes obstruction temporarily. Even if bile does not flow for four or five days it is no evidence that the obstruction has not been relieved.

The case reported is certainly an illustration of the good that may be done by cholecystotomy.

H. A. COTTELL, M. D., *Secretary.*

THE LOUISVILLE CLINICAL SOCIETY.*

Stated Meeting, May 16, 1893, Dr. I. N. Bloom, President, in the chair.

Dr. A. M. Vance (Discharge of Pus at the Navel following an Attack of Typhoid Fever): I saw a few days ago a little girl nine years of age with a history that thirteen weeks ago she was taken with typhoid fever. According to Dr. Rudell, who is the family physician, this disease ran a typical course up to seven weeks, when the umbilicus became tender, not very red, but pouted a little, and about two weeks afterward a small opening occurred and a great deal of pus was discharged. The doctor treated it expectantly for four or five weeks, up to the time I saw the patient last Friday. I advised exploration and more thorough drainage. The child was in an extreme condition, having emaciated almost to the last degree, was suffering with hectic fever, and was in a very forlorn condition in every way. I was afraid to give chloroform, but had to do so to perform an abdominal section. An incision was rapidly made in the median line, using the umbilicus for the center, and a great quantity of pus was evacuated along with solid material, which I thought at the time might be fecal matter. The pus was very fecal in odor. I found the abdominal wall from the ribs to the ilium had

* Stenographically reported by C. C. Mapes.

entirely separated from the parietal peritoneum, and this surface was suppurating from the opening back to the kidney region on either side. I passed my hand around on each side to discover if possible the source of this abscess, but could not find any perforation. The whole area was thoroughly washed out and stuffed with strips of iodoform gauze on each side. Since then the child has been very much better, eating, constantly calling for food, sleeping well, and has been very much more comfortable. To-day I found that the gauze would not drain well toward the umbilicus, and I made counter-openings as far around as I could reach with a probe, and put in two large rubber drainage-tubes to either side from the umbilicus. Drainage has been perfect since. I believe the trouble was due to a perforation of the intestine at a point where there was an adhesion to the parietal-peritoneum, and the pus seeking a point where there was the least resistance, finally discharging at the navel, where there possibly was a little hernial weakening.

I have never seen a case like it; it is something new in my experience, and I thought a report of it might be of interest to some of the Fellows. I am convinced that there was a fecal opening somewhere, probably in the right iliac region.

Dr. J. G. Cecil (Perforation of Gut in Typhoid Fever and Discussion): Dr. Vance's remarks recall to my mind a case of typhoid fever in a colored woman in the City Hospital, that had a perforation of the gut; but it was never diagnosticated nor suspected until after death, and the *post-mortem* revealed the true state of affairs. In that case we found evidences of general peritonitis, but more particularly in the region of the cecum and small intestine; wherever we found Peyer's glands there was localized peritonitis, with an accumulation of fecal matter, pus, etc., of a very offensive character. I was particularly interested at that time to know that a case of typhoid fever might suffer a perforation and not yet give any of the classic signs, sufficient at least to lead to a diagnosis. I am sorry that I can not recall more correctly the exact facts in the case. The patient lived probably several days after the time we supposed this perforation took place. Of course, not knowing that there was a perforation, we could not ascertain to a certainty when it did occur, but after recalling the history of the case, it being substantiated at the *post-mortem*, we thought probably it occurred several days before death.

The case related by Dr. Vance seems to me to be a very extreme one. He suggested the other day in private conversation that it must

have been due to a perforation, and from the history of the case I do not see how there can be any other rational explanation of it.

Dr. J. M. Mathews (Abdominal Pain Following Typhoid Fever): A young lady consulted me to-day with the following history: She is about twenty-one years of age, and had an attack of typhoid fever eight months ago in the city of New York. She said that the attack was accompanied with several very distinct and large hemorrhages from the bowels; that after she made a recovery she felt a pain which was aggravated upon exercise, going up stairs, or any thing of that kind, continually; that she was forced to use even now an abdominal supporter; that she consulted her physician, who was an eminent physician in New York, and he told her that with this history of typhoid fever accompanied with hemorrhages, and with this pain, she evidently had extensive adhesions, and warned her that should she have an acute attack at any time to immediately consult a surgeon, because an operation would be necessary. The reason she consulted me was that she states if she goes one day without evacuation this pain is set up with great intensity, and that she has to at once open her bowels with an aperient.

On questioning, and with a partial examination of the case, I found that she referred the pain nearly directly to the McBurney point, and she gives the history of having had several distinct attacks of pain, which would indicate more or less appendicitis, and I was inclined to think, or at least the question arose in my mind, whether or not it was not separate and distinct from her attack of typhoid fever; in other words, outside of Peyer's patches; whether or not the appendix was involved, having no connection with the attack of typhoid fever. She is impressed that she will possibly need a surgical operation, as she has been warned that this might be the case.

DISCUSSION.

Dr. Wm. Bailey: Basing the idea of perforation upon fecal odor, is it not possible, owing to the thinness of these structures, to have a fecal odor without perforation?

Dr. Vance: Yes, I think this is quite possible, and may have been the cause of the fecal odor in the case I reported, but there was considerable material looking like fecal matter in the right iliac fossa. There is one point I failed to mention in the history: I gave the child a purgative the day after the operation, and she had several large evacua-

tions, and my attention was called to the peculiar character of them, looking like they were filled with thousands of little bodies; the whole mass seemed to be filled with little worms. I could not make out what it was at first, but finally came to the conclusion that it was the little fibers of banana that go from the center to the periphery of the banana; the child had eaten a great quantity of bananas even the day before the operation.

Dr. William Cheatham (Intubation for Papilloma of the Larynx): I will now make a continued report of a case of intubation, a child about three and a half years old, which I had to tube for papilloma of the larynx, making pressure, thus hoping to produce absorption. The child has worn the tube since September last, having been changed three times in the mean time. The father telephoned me the other day that the child had coughed the tube out, and I asked him to bring the child to my office. He did so, and gave me the history that the child dropped in the back yard as if in a shock, and the mother found the tube partially out and pushed it back; I found the tube in position, but turned half around. Could not get it out without the extractor. I had to milk it out by putting my right fore-finger in his mouth and placing left thumb below tube on larynx by firm pressure up and back. I finally succeeded in getting it out. This was last Monday, and the child has not had to have the tube inserted since, and the breathing has been perfect without it. It is marvelous how these little ones get used to the tube. In removing this tube I did not have to use a gag to hold the mouth open. He held his mouth open each time and allowed me to use the extractor without any trouble.

I have two cases on hand now of paralysis of the left recurrent laryngeal. One of them interested me a great deal in which there was at first paralysis of the recurrent laryngeal, which supplies the abductor and adductor and the arytenoid muscle. Some gentleman has taken this nerve and dissected the three fibers, showing them separately. This case had adductor paralysis at first, the cord being firmly contracted and drawn over to the left. We did not know what was the cause at first, but later it has been found that he has an aneurism of the aorta. His voice was exceedingly bad; he was very hoarse, as is usually the case with adductor paralysis. In the last few days he has improved very much. Upon examination I found complete paralysis of the left vocal cord; it having taken the cadaveric position, the right cord now does not have to go over so far.

In the other case of paralysis of the left recurrent I have not yet been able to make out any cause. I have also a young lady with paralysis of the arytenoideus muscle, with loss of voice six months. I do not know whether it is a case of hysteria or not. She has menstrual trouble. I have not been able to find any local cause for the paralysis.

T. C. EVANS, M.D., *Secretary.*

Reviews and Bibliography.

Brain Surgery. By M. ALLEN STARR, M. D., Ph.D., Professor of Diseases of the Mind and Nervous System, College of Physicians and Surgeons, Medical Department of Columbia College, New York; President of the New York Neurological Society; Consulting Neurologist to the Presbyterian, Orthopedic, and Babies Hospitals. with fifty-nine Illustrations. Octavo, 308 pages, extra muslin, price, \$3. New York: William Wood & Company.

It is not every book that a man feels loth to lay by before he has finished it when the thermometer is in the nineties, but this book certainly belongs to that class. It opens with a clear statement of what is known of cerebral localization, and then follows with the designation of the character of cases in which one should operate. In epilepsy it is the Jacksonian form—that which begins in one group of muscles and then extends to the rest of the body—that he thinks amenable to treatment by trephining.

Traumatic epilepsy generally, he thinks, may be so treated when the nature of the existing symptoms or the injury point clearly to a localized and accessible source of the epileptic trouble. That a simple injury of the scalp, or even of the bone, where there is no evidence of depression, is not a clear warrant for operation is shown by the history of wounds made in other parts of the body and followed also by epilepsy. Thus the records show that of those wounded in the head in the Franco-Prussian war one in about two hundred became epileptic, while one in two thousand of those wounded in the body or extremities became so. That is, epilepsy is followed ten times as often in wounds of the head as in wounds in other parts of the body.

About thirty new cases with results have been collected and appended by the author, with the remark that he had collected those in which the reports were sufficiently exact and sufficiently reliable. The worth of the author's reports are by nothing better shown than that he does not refer to some remarkable cases reported by certain well-known wonder-workers, the very mention of whose names in a book would detract greatly from its value, as showing a want of proper discrimination in the author. Of course his percentage of results relates only to reported cases, and probably give very

little indication of what the actual showing would be if all unsuccessful cases were reported.

In cases of traumatic hemorrhage the author lays down nearly the same rules as in epilepsy. The injury to the brain must be clearly located. Non-traumatic hemorrhages are very seldom open to operation.

Extreme care is enjoined in the selection of cases of tumor for operation, nor does the author believe that operations to remove abscesses and cicatrices without some risk of unfavorable after-results. Cicatrices must inevitably follow any wound that is made in the brain, for the void left by removal of brain substance can be filled only by connective or scar tissue, and in this operation scars may as well cause epileptic and other troubles as may the original lesion. Hydrocephalus and idiocy offer but little promise, likewise does insanity. So in headache the operation is to be done only where there is indication of depressed bone.

All in all this work of Dr. Starr can justly take its place not only in the library, but even on the table, as a safe and conservative guide to both physicians and surgeons.

D. T. S.

A Hand-book of Local Therapeutics. General Surgery, by RICHARD H. HARTE, M.D.; Diseases of the Skin, by ARTHUR VAN HARLINGER, M. D.; Diseases of the Ear and Air-Passages, by HARRISON ALLEN, M. D.; Diseases of the Eye, by GEORGE C. HARLAN, M. D. 505 pp. Price, \$4. Philadelphia: P. Blakiston, Son & Co. 1893.

The need for a book of this character has long been apparent, for there has been no text available in which the local action of drugs was not subordinated to their general actions, while the average text-book omits altogether the mention of many agents that in the hands of a specialist become valuable aids to cure.

Diseases which require chiefly local treatment are those of the respiratory passages, eye, ear, and skin, together with certain general surgical affections, including diseases of women; it is therefore to the great advantage of the work that each remedy has been thoroughly set forth by different authors who have had large practical experience in these various branches.

Each remedy has been taken up in alphabetical order, and after a description of its pharmaceutical properties is considered in reference to its physiological effect and value in local treatment.

The demands for thorough revision of local medicament made by the advance of theories of asepsis have been fully considered, and a succinct account has been presented of the source and properties of the very numerous new agents which affect tissues locally.

Some drugs have been excluded, which have been highly praised; on the other hand great care has been taken not to indorse imperfectly attested novelties.

This hand-book embodies the results obtained by experienced teachers, and will prove a very valuable work to the general practitioner. Two carefully made indexes make it a book of ready reference.

The Diseases of the Nervous System. A Text-book for Physicians and Students. By DR. LUDWIG HIRT, Professor at the University of Breslau. Translated, with permission of the author, by August Koch, M. D., assisted by Frank R. Smith, A. M. (Cantab.), M. D., Assistant Physicians to the Johns Hopkins Hospital, with an Introduction by William Osler, M. D., F. R. C. P., Professor of Medicine in the Johns Hopkins University.

In his introductory to this work Dr. Osler declares that no better corrective exists to the vice of Philistinism, that narrow conceit of the special prominence of medicine in any one country, than a wide diffusion in all of the best works of each. And yet, while this author does not decry the work of foreigners, it would not, in our opinion, be easy to find a book of its class in which authors of other countries are more nearly ignored. An exception must of course always be made of Charcot; for not to give Charcot credit is not to write on nervous diseases. Our greatest objection to the work is that it is not a picture-book. There are enough illustrations, and they are often new, though not up to the usual style of the Appletons in the matter of execution. But it is not this that we refer to. The author does not give a clear mental picture of his subject. The perspective is not good. Unless you go elsewhere for your knowledge than to the author's descriptions one part comes like another in monotonous sequence. It is defective in philosophical suggestiveness. Nevertheless the teachings are sound and judicious as far as pathology goes, though we think, in the matter of treatment, the author lays more stress on the use of electricity than the facts justify or ever will justify. One might find much in it to throw a side light upon subjects not sufficiently illuminated by treatises already in the field; but in every important regard it is, in our opinion, distinctly inferior to the classic work of Gowers, and even of several others already before the profession.

D. T. S.

Atlas of Clinical Medicine. By BYRON BRAMWELL, M. D., F. R. C. P., Edin., Assistant Physician to the Edinburgh Royal Infirmary, etc. Vol. 2, Part 2. 40 pp. Edinburgh: Printed by T. and A. Constable at the University Press. 1893.

This fascicle of Dr. Bramwell's superb work maintains the high standard of the previous numbers, and is accompanied by an unusually large number of plates. It is devoted to alterations in the field of vision, syphilis, Asiatic cholera, and Friedreich's disease. One thing in it we had hardly expected to find the author taking up his time with, and that is a serious consideration of the propriety of using hypodermic injections of mercury in the treatment of syphilis, though, it need not be said, not to approve it.

D. T. S.

Eighteenth Annual Report of the State Board of Health of the State of Michigan for the Fiscal Year ending June 30, 1890.

While the report of the Michigan Board of Health continues, as evidenced in this volume, to hold its place well in the forefront of all works of its kind, the rule it has adopted of publishing only such papers as are

approved for such purposes by a majority of the board might be pushed still further with advantage. The proof-reader is the only man that ever did or ever will get through it, except possibly the person who compiled it.

D. T. S.

MISSOURI STATE MEDICAL DIRECTORY, containing a carefully revised list of Physicians, Dentists, and Druggists, together with the Colleges, Hospitals, Societies, and Medical Journals of the State, arranged by counties for convenience of Society Secretaries. Pocket size, 120 pp., cloth, gold embossing. Published by The Medical Fortnightly, 1006 Olive Street, St. Louis. Price, \$3, post-paid.

Abstracts and Selections.

TREATMENT OF OBESITY AND FATTY DEGENERATION.—(G. H. Thompson, A. M., M. D., Professor Materia Medica, St. Louis College of Physicians and Surgeons.) It is not necessary to enter into a discussion of what constitutes fatty degeneration, suffice it to say that this condition generally co-exists with a tendency to general obesity or results from the abuse of alcoholics. Those having a tendency to general obesity are usually partial to diets rich in sugars and starches, and small amounts of carbo-hydrates added to such diet greatly favors the deposition of fat. The hereditary tendency to accumulation of fat, in my experience, usually manifests itself in males at the age of thirty, sometimes earlier, sometimes later; in females usually at about twenty-eight. As long as fat serves its functions only (that of adding rotundity to the form and serving as food supply in times of sickness) there is no necessity of seeking to eliminate it. It is when it accumulates persistently, causing distress by its weight and interference with locomotion, or when internal viscera become so degenerated by substitution of fat for normal organic tissue, that distress is caused or life threatened, that we should seek to correct its effects.

The members of the medical profession doubtless have their own ideas as to whether relief should be given on purely cosmetic grounds or not, and it is not my intention to discuss this subject from such a standpoint. The question is, how can necessary relief be afforded? In endeavoring to throw some light on this question I take occasion to report a few cases.

CASE I. Mrs. E., aged twenty-eight, weight 139 pounds, height 5 feet, complained that she suffered from heat. For two years she has been unable to stand the moderate summer elevations of temperature without great inconvenience. Perspired so freely that she was obliged to remain indoors most of the time between June and September on account of ruining her

clothes with perspiration. No female or other trouble was present, but she seemed to have a superabundance of adipose tissue generally distributed, especially about the chest and abdomen; habits regular, bowels and courses likewise. Concluded to see the effect of reducing her weight, and for this purpose, after trying *fucus vesiculosus* in the dose of one to two drams of the fluid extract three times a day, with some slight benefit, I determined to try *phytolacca decandra*, which has been recommended by Dr. M. M. Griffith as a potent measure in diminishing obesity. The preparation used was *phytoline* (Walker), a remedy prepared from the active principle of the *phytolacca* berries, after being somewhat frost-bitten. The dose first used was gtt. xv four times a day. The patient used two bottles, after which she reported herself feeling very much improved, perspiration lessened, weight 128 pounds, appetite about the same, regular bowels and courses. I could find no bad effects from the remedy.

CASE 2. H. W. M., aged thirty-three, weight 160, height 5 feet 6 inches, complained of precordial distress, difficult breathing, occasional attacks of vertigo; heart-beat feeble, irregular, and slow, sometimes rapid; anemia; weakness in the legs, which were not very muscular. Patient was addicted to alcoholics, suffered consequently from dyspepsia and atony of the bowels. Diagnosis: Fatty degeneration of the heart due to alcoholism. Stopped his alcoholics, administered stomachic tonic of quinine, strychnine, and capicum, and gave *phytolacca* (*Phytoline*, Walker's) in the dose of gtt. x six times a day, before and after each meal. In three weeks' time there was a notable improvement in every respect. Weight had decreased five pounds, heart-beat fuller and more regular, precordial distress and difficult breathing ceased altogether, digestion improved, appetite likewise. Patient was on the road to recovery when persistent exposure to extreme cold brought on pneumonia, from which he died after five days' illness.

In these two cases there was no advice given as to diet except the withdrawal of alcoholics in the last case, it also being remembered that alcoholics antagonize the action of *phytolacca*.

CASE 3. Mr. N., aged fifty-four, weight 240, height 5 feet 10 inches, complained of eczema of the legs and left side. Inspection showed in the left hypochondrium a large circumscribed ulceration about two inches in diameter, surrounded by inflamed vesicular area; the legs showed similar ulceration in the skin. Patient perspired freely, almost to a point of hyperidrosis. During cold weather patient was not troubled except from difficult locomotion and occasional attacks of rheumatism. Examination of urine showed no sugar. Appetite fair, drank considerable beer, bowels regular. Astringent salves and lotions cured temporarily. Diagnosed eczema, due to maceration. Placed patient on *phytolacca* (*Phytoline*, Walker's) gtt. xxv before and after each meal. In two weeks patient lost 10 pounds, had somewhat less appetite, less perspiration, sores took on a healthier condition, and after continuing the treatment about two months and a half patient felt as well as ever, and tipped the beam at 200. Since then the patient has gained

but little if any, perspires normally, and has no return of his eczema and no recurrence of rheumatism. How long this condition will last time alone can tell.

This last case was one especially calling for some fat-reducing agent, and the checking of perspiration. In this case bread and potatoes were prohibited, and other forms of starchy foods; beer was reduced in quantity two thirds. These measures materially increased the fat-reducing properties of the phytoline.

The next question is, how does phytoline cause the reduction of fat? This I am at present unable to say. I have, however, noticed that the feces seemed to be considerably more rich in fatty materials than is normal, which condition can not be attributed to indigestion, as in all other respects digestion was normal. Perspiration and urine were apparently unchanged by the action of the drug.

Offical preparations of the root have been used with little or no result, except to cause continued nausea, vomiting, and diarrhea. Phytoline does not cause nausea in the ordinary dose, and, though slight laxative effects have been observed from it, I have never seen a pronounced case of diarrhea.

The appetite is sometimes slightly diminished, chiefly in the morning. It seems to me to be specially indicated in all diseases characterized by fatty degeneration of internal viscera, especially of the heart and liver. Those who choose to use it for its cosmetic effects in reducing fat will also find in it a serviceable adjunct to properly restricted diet and exercise.

REST IN BED.—Dr. Guy Hinsdale, in the course of a lecture on nursing in nervous disease, particularly hysteria, describes the advantages to be derived from ordering absolute rest in bed:

It will seem somewhat strange to those who have been accustomed to go about the house, although in a languid manner. It will be far better also for invalids who recline on sofas, and yet have not cared to relinquish all opportunity of seeing friends, and hearing of the outer world. By going to bed in earnest, and under no pretext walking about the room, not even sitting up, and in some cases not even feeding herself, the patient realizes that a new era has begun in her life history. The result is that she appreciates highly the opportunity to feed herself when the permission is given, perhaps after a fortnight or more of denial. At the end of a month or so she sits up a few minutes each day; the time is lightened; at the end of two months, perhaps, she is allowed to sit in a chair. Every added privilege is appreciated as never before; liberty never seemed such a boon. It is like the hunger of a convalescent from typhoid fever. The whole aim in life, if you have maintained the case successfully, is now to occupy a sphere that before seemed impossible to attain, and with timely assurance you will have the satisfaction of seeing the patient launched upon the world made over anew. These are matters of actual experience.—*Boston Medical and Surgical Journal.*

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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This journal is devoted solely to the advancement of medical science and the promotion of the interests of the whole profession. Essays, reports of cases, and correspondence upon subjects of professional interest are solicited. The editors are not responsible for the views of contributors.

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THE MODERN TREATMENT OF ALCOHOLISM.

Since 1887, when the results of the clinical experiments of Tolonisky and Partivisky were given to the world, much has been done in the treatment of alcoholism by means of strychnia. These observers found that strychnia in increasing doses of from a sixtieth to a thirtieth of a grain, three times a day, were followed by most encouraging results in the management of chronic alcoholic habits.

Following their lead, the physiologist Jaroekosky instituted a series of experiments upon dogs, which led him to conclude "that strychnine enables the animal organism to receive large quantities of alcohol without any apparent injury to the nervous system."

The Boston Medical and Surgical Journal of the 24th inst., in an interesting editorial digest of this question, says:

Pombrak found strychnia a valuable remedy both in cases of chronic alcoholism and in those of dipsomania, not merely curing the attacks, but abolishing the desire for drink. Even attacks of delirium tremens were influenced beneficially. He began with doses of one thirtieth of a grain; in more severe cases with one fifteenth of a grain.

It is worthy of note that Luton, of Rheims, first called attention to the remedial effects of nux vomica in alcoholism nearly twenty years ago. He was in the habit of administering one half grain of the extract or ten drops of the tincture three times a day in alcoholic trembling, in the cerebral troubles due to alcoholic poisoning, etc. It was Luton who called nux

vomica the medicine of drunkards. Luton, however, recognized that nuxvomica can have no beneficial effect when the alcoholism has arrived at the phase of plastic infiltrations and of granulo-fatty degenerations. Luton afterward made trial of strychnine in hypodermic injections, and found that this drug when thus administered had marvelous efficacy in delirium tremens. Dujardin-Beaumetz adopted this mode of treatment in delirium tremens, with equally favorable results. He used the following prescription :

Sulphate of strychnia, 10 centigrams ;
 Cherry laurel water, 10 grams ;
 Distilled water, 10 grams.

A hypodermic (Pravaz) syringe-ful contains five milligrams (one twelfth of a grain). In cases of furious delirium he makes an injection every half hour till four injections are given ; then every hour till the delirium is subdued. It is not an uncommon thing to practice these injections till two to four centigrams (one third to two thirds of a grain) of strychnia are thus administered ; and this treatment is pronounced " safe."

Lecuye, a pupil of Luton, who in 1882 wrote a treatise on "Alcohol and Strychnine," reports similar successes in the use of strychnine, and considers this drug as the remedy *par excellence* of the nervous, cardiac, and gastric troubles of alcoholism.

The strychnine treatment of alcoholism has been tried in this country and in England with varying success, and has been adopted in many institutes for the cure of inebriety as a part of routine practice. Experience seems to be daily justifying some portion at least of the claims made for this drug by the enthusiastic advocates of its use in the treatment of alcoholism (and not the least of its merits is said to be its wonderful power of sustaining the heart under conditions of extraordinary depression), but it can not be relied on to the exclusion of other remedies as nerve sedatives and hypnotics, or of the proper hygienic treatment.

The physiological effects of alcohol and strychnia suggest at once an antagonism which might be turned to account in the treatment of the liquor habit. The continued use of alcohol paralyzes the vaso-motor nerves, and the arterioles, no longer able to maintain their proper caliber and thus regulate the distribution of blood to the capillaries, present that sorry degree of varicosity which is recognized as the alcoholic bloom (the "rum-buds" of the poets) in the face of the drunkard. This condition of the cutaneous arterioles is but the index of the condition of the vessels of the delicate organs situate within the cranial and splanchnic cavities. In short, the blood-distributing apparatus of the whole man is out of order ; the tendency of the blood is to stagnate in the capillaries, and the heart must be whipped up to unusual activity to give the *vis a tergo* necessary to the return of the blood to the

right auricle. Thus it is that the hard drinker of the night must seek in the morning the *similia similibus* (?) of fresh potations to brace him for the work of the coming day; and thus it is that the heavy day-drinker, waking in the small hours of the night, must arise and drink before he can find sleep again. If this state of affairs continues the victim must sooner or later succumb, because of the failure of an over-worked heart, or the degeneration of vital organs whose nutrition suffers in consequence of the stagnation of the blood sent to them, which in turn is often insufficiently charged with nutritive pabulum and is always charged with the poison alcohol.

If the above be true, the *methodus medendi* of alcohol is mechanical rather than chemical, and the desire of the drunkard for more drink is the cry of the tissues for increased heart-force and a better capillary circulation.

The only drug which seems to meet this demand is strychnia, since it not only stimulates the vaso-motor nerves, and causes them to contract the muscular fibers of the arterioles, but at the same time gives force and tone to the overtaxed heart. And if this be true, then it is not too much to expect that strychnia will not only help the drunkard (if not too far gone) to recover from the effects of alcohol, but that it will quench in him the desire for liquor.

It is upon the basis of the experiments and observations above noted that most of those who essay to treat drunkards to-day are working, and our object in thus commenting upon it is that physicians may be admonished not to be in a hurry to send their alcoholic patients to the much-advertised money-grabbing institutions established for the treatment of the liquor habit. The restraints of a well regulated sanitarium may be necessary in some cases, but the majority of alcoholic habitues, that is, those who have not reached the degenerative stages of alcoholism, and who really want to give up strong drink, may be better managed at home. As for the others, the history is that the first come back from the sanitariums to enter the insane asylums or to die, while those who lack the moral incentives to temperance and sobriety return to go back to their cups.

Notes and Queries.

THE WILLIAM F. JENKS MEMORIAL PRIZE.—The third triennial prize, of five hundred dollars, under the deed of trust of Mrs. William F. Jenks, will be awarded to the author of the best essay on "Infant Mortality During Labor, and its Prevention."

The conditions annexed by the founder of this prize are, that the "prize or award must always be for some subject connected with Obstetrics, or the Diseases of Women, or the Diseases of Children," and that "the Trustees under this deed, for the time being, can, in their discretion, publish the successful essay, or any paper written upon any subject for which they may offer a reward, provided the income in their hands may, in their judgment, be sufficient for that purpose, and the essay or paper be considered by them worthy of publication. If published, the distribution of said essay shall be entirely under the control of said Trustees. In case they do not publish the said essay or paper, it shall be the property of the College of Physicians of Philadelphia.

The prize is open for competition to the whole world, but the essay must be the production of a single person.

The essay, which must be written in the English language, or if in a foreign language, accompanied by an English translation, should be sent to the College of Physicians of Philadelphia, Pennsylvania, U. S. A., before January 1, 1895, addressed to Horace V. Evans, M. D., Chairman of the William F. Jenks Prize Committee.

Each essay must be type-written, distinguished by a motto, and accompanied by a sealed envelope bearing the same motto and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The committee will return the unsuccessful essays, if reclaimed by their respective writers, or their agents, within one year.

The committee reserves the right not to make an award if no essay submitted is considered worthy of the prize.

JAMES V. INGHAM.

Secretary of the Trustees.

AUGUST 1, 1893.

THE seventeenth annual meeting of the American Dermatological Association will be held in Milwaukee, Wis., September 5, 6, and 7, 1893. Officers for 1893: President, George Henry Fox, M. D., of New York; Vice-President, Henry W. Stelwagon, M. D., of Philadelphia; Secretary and Treasurer, George T. Jackson, M. D., of New York. Council: E. B. Bronson, M. D., G. H. Fox, M. D., G. T. Jackson, M. D., Henry W. Stelwagon, M. D., J. C. White, M. D.

Special Notices.

A PRACTITIONER devoting especial attention to the diseases of children says: In the treatment of choleraic diarrhea we are safe, it matters not at what time we may be called, in administering some antiseptic medication, something which will prevent fermentation and have a destructive effect upon the septic germs more than likely present in the alimentary canal. Happy effects are often secured by the use of LISTERINE properly diluted. A favorite prescription is the following:

| | | |
|--|---|------------------|
| R Lambert's Listerine, Glycerine (c. p.), Syr. simpl., Aquæ cinnamon, | } | aa 3j. |
|--|---|------------------|

M. Sig: Teaspoonful every one, two, or three hours, as may be indicated.

Taking into consideration the component parts of LISTERINE, it impresses me favorably as a prophylactic and remedial agent for cholera, along with other intestinal disturbances. The eucalyptus, thyme, gaultheria, and boracic acid which it contains are all antagonistic to germ life and oppose fermentation. The preliminary diarrhea (cholera, as it is called) may well receive teaspoonful doses of LISTERINE combined with the same amount of glycerine. In fact I should be inclined to recommend to the laity this combination as a prophylactic measure.

SENILE DEBILITY:

| | | |
|---|-------------------------------------|---------------------------|
| R Syr. Hypophos. Comp., Celerino (Rio), Acidi Phosphorici dil., | | 3 oz.; 2 oz.; 1 oz. |
|---|-------------------------------------|---------------------------|

M. Sig: Teaspoonful four times daily.

CONGESTION.—It is wonderful, when one comes to think of it, how many diseases are caused by congestion, and also how many diseases can be cured by relieving or removing the congestion. When there is too much blood in the head, causing what is called cerebral congestion or congestive headache, we have an infallible remedy—one that is always handy, always pure, and always of uniform strength. This valuable remedy is known to every physician in America and Great Britain as Peacock's Bromides. If this preparation fails to relieve, one always knows that either the diagnosis is wrong or a substituted preparation has been used, therefore the genuine Peacock's Bromides is an infallible test as to the character of the headache. The same is true in regard to uterine congestion, congestion of the lungs, throat, kidneys, bowels, etc. If, then, so many diseases are caused by congestion, it naturally follows that, the cause being one—congestion—the cure is one—to remove the congestion: the remedy is one—Peacock's Bromides, together with whatever collateral treatment that may be indicated.

I have used Cactina Pillets, and find them very valuable in common heart troubles when weakness and irregular action is manifested. I shall use them in the future.

BOSTON, MASS.

ALBERT DAY, M. D.,

Superintendent and Physician of Washington Home.

JOSEPH P. ROSS, A. M., M. D., Professor of Clinical Medicine and Diseases of the Chest, Rush Medical College, Chicago, Ill., says: For the past three years I have prescribed BROMIDIA very frequently, and have never yet been disappointed in securing the results required. In cases where there is Insomnia without pain, in the delirious stages of acute fevers, in delirium tremens, puerperal mania, in short in all those cases requiring soporifics, I find BROMIDIA invaluable. I consider BROMIDIA an excellent combination.

THE
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"NEC TENUI PENNĀ."

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No. 5.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

VITAL AND MORTUARY STATISTICS OF KENTUCKY FOR 1892.*

BY T. B. GREENLEY, M. D.

You perceive that I am again at my post as reporter of the Vital and Mortuary Statistics of the State.

It may be said, when you have to work with nothing to work on, the task is more laborious than if a due supply of material was at hand.

For several years I have been at work on this subject without any material of our own to work on or to base a report on, having to *borrow* from the United States census reports for data.

I felt confident that by this time the volumes pertaining to population of the census returns for 1890 would have been published, so that I could make a report from them for our State the present year, by computing a ratio of increase in births and deaths for the past two years.

On writing to Dr. Billings, U. S. A., on the subject, he was kind enough to do me the favor of sending me an abstract of the data pertaining to statistics of life and death. He says:

DEAR DOCTOR: The census data for 1890 with regard to the vital statistics of Kentucky are not yet published, and in fact are not as yet compiled in a shape to be of much value for your purpose. Nevertheless, it is certain that these census reports of Kentucky, as regards death-rates, are very incomplete and unsatisfactory.

The total number of deaths reported during the census year by the enumerators for Kentucky was 23,877. The population of the State was

*Read at the May meeting of the Kentucky State Medical Society, 1893.

1,858,635, which would give a death-rate of 12.8 per 1,000. The true death-rate was probably about 16, that is, there were probably about 30,000 deaths in the State during the year. The deaths reported by the census enumerators among the native born whites numbered 17,446; among the foreign born whites, 1,177; of whites whose birthplace was unknown, 775; 4,479 deaths were reported among the colored. Of deaths under five years of age 6,789 were reported among the whites, and 1,572 among the colored. The number of deaths reported for special causes was as follows: Whooping-cough, 539; scarlet fever, 107; measles, 513; diphtheria and croup, 1,115; typhoid fever, 1,048; malarial fever, 514; diarrheal diseases, 1,671; cancer and tumors, 412; consumption, 3,538; pneumonia, 1,924; childbirth and puerperal diseases, 298.

These are all the data which I have at present which would be of special interest for your purpose. While you can not get death-rates that would be of any value, that is to say, death-rates calculated from the number of deaths to the number of living population, the proportion of deaths from certain causes can be calculated from the above figures and may be of some interest.

Regretting that I can give you no more satisfactory information, I remain, yours very sincerely,

JNO. S. BILLINGS,
Surgeon U. S. A., in charge of Vital Statistics, etc., Eleventh Census.

In my report to this Society last year, I made the population of the State to be 2,194,300. This calculation was based on the ratio of increase from 1870 to 1880, the increase being 27.5 per cent in the decade, and if the same per cent is added to the population as reported in 1880, it would be as I stated in my last year's report, 2,047,000, instead of 1,858,635, as reported by the enumerators for 1890. Then, if we add 27.5 per cent to the census report of 1880, we have for the year 1892 a population of 2,230,400, an increase in twelve years of 545,810, equal to 32.5 per cent.

As I remarked in my last report, this is a reasonable calculation, as it is presumable that the increase of population would continue to be as great from 1880 to 1892 as it was from 1870 to 1880, as we have had no epidemics worthy of notice during that time, and that from what we can learn immigration was fully as great or greater than for the former decade.

Then it strikes us as being very evident that the enumerators of the last census omitted to report a very large number of our population.

As Dr. Billings remarks, the number of deaths as reported no doubt is incorrect, which he thinks should be about 30,000, which would make the death-rate, as he states, about 16 per 1,000 of the population instead

of 12.8. But if we had a correct enumeration of the people, the death-rate would not be as high as the Doctor's estimate. If we base the death-rate on my estimate of the population in 1890, which was 2,047,000, we would have a death-rate of 14.157 to 1,000, concluding Dr. Billings' estimate of 30,000 deaths to be correct. This rate of mortality approaches very closely to that of 1880, which was 14 per 1,000. The mortality reported for 1880 was 23,718, varying but little from that of 1890, being only 119 less.

The number of children born in 1880 was 52,982, or 1 to 31.43 of the population, and the rate of births to deaths was 2.24 to 1. The rate of males was 1.19 to 1.17. The deaths of 1880 over those of 1870 was 9,373, showing a heavy increase in mortality, but the latter named year was unusually healthy, the rate of deaths being only 10.86 per 1,000. The increase of births was 10,961, or 26 per cent. If you make the same ratio of increase from 1880 to 1892 the number of children born in the latter year would be 63,578.

The census of 1880 shows that of all children who died under five years, 60 per cent died under one year of age. The deaths of children under five years old reported for 1890 was 8,361, or 35 per cent of the mortality.

The following statement shows the difference in the mortality from the diseases named between the census years 1880 and 1890:

The mortality from scarlet fever in 1890 was 107, and 515 in 1880; measles, 513 in 1890, and 258 in 1880; whooping-cough in 1890, 530, and in 1880, 313; diphtheria and croup, 1,115 in 1890, and 1,119 in 1880; malarial fever, 514 in 1890, and 763 in 1880; diarrhea, 671 in 1890, and 248 in 1880; puerperal fever and childbirth, 298 in 1890, and 408 in 1880; typhoid fever, 1,046 in 1890, and 710 in 1880; cancer and tumors, 412 in 1890, and 283 in 1880; consumption, 3,538 in 1890, and 2,937 in 1880; pneumonia, 1,924 in 1890, and 1,642 in 1880. The deaths from these diseases, in the aggregate, amount to nearly 45 per cent of the whole mortality for 1890, and are 1,557 greater in number than those from the same causes reported in 1880.

The mortality in the city of Louisville as per report of Health Officer Dr. Galt, for the year 1892, was 3,384 against 3,087 for 1891, being .087 per cent greater than that of the latter year; perhaps, however, no greater than the increase of population. There were 1,756 males and 1,628 females; 2,486 whites and 898 colored; single, 1,689; married, 1,524; not stated, 171. Died from accidents—railroad, 29; burns and

scalds, 28; all others, 52; drowning, 12; homicide, 28; hanged, 1; suicide, 21; poisoning, 10. In all from these unnatural causes, 182.

In numbers consumption stands at the head of the list, 381; pneumonia, 253; old age, 228; heart diseases, 160; inanition, 157; typhoid fever, 116; bronchitis, 120; diphtheria, 102. Natives of the United States, 2,504; foreign birth, 880. Deaths under one year, 586; one to two years, 150; two to five years, 209; five to ten years, 135; ten to twenty years, 217; twenty to thirty years, 377; thirty to forty years, 312; forty to fifty years, 276; fifty to sixty years, 303; sixty to seventy years, 327; seventy to eighty years, 258; eighty to ninety years, 126; ninety to one hundred years, 18; over one hundred years, 6; age not stated, 74.

The population of Louisville at present is estimated to be at least 200,000, which would make the mortality 16.90 per 1,000. When we take into consideration the greater mortality among the colored people we must conclude this to be a light death-rate when compared to many other cities in the Union. In fact, there are but three cities in the South where the death-rate was not greater in 1890 than in our metropolis, and in two of these, if we count the difference between the death-rate of the negro population and the whites, Louisville will stand equal with them. The two cities alluded to are St. Louis and Atlanta.

Nashville is reported to have had a less death-rate than any city in the South for 1890. And if we compare the mortality of Louisville to that of the northern cities, we find only three, as reported, below that of Louisville; these are Indianapolis, Rochester, and Worcester. The average mortality of the colored people of the cities of the United States in 1890 was 11.30 per cent greater than that of the whites.

It will be perceived that even the city of Louisville is still without childbirth statistics.

It will be remembered by this Society that I have been the committee to report on the vital and mortuary statistics of the State for several years past, and that I have complained in each report on account of having no statistics of our own to report on, having to resort to the decennial census report of the United States, and make ratio calculations as to the birth- and death-rate for the year being reported. This is no little work; but your reporter would care but little for the labor if he was satisfied of its near approach to correctness. But, of course, we can only base our calculations on the births and deaths of every tenth year. We all know that these rates vary from year to year from differ-

ent causes in action, and no positively accurate report can be made for any particular year on what took place in a year a decade since. But under the circumstances it is as near as we can come to our birth- and death-rate.

I had hoped at our last meeting that I should have been able to report some progress in the way of obtaining a statistical account pertaining to our population by the time of our regular meeting this year, but so far there has been no advance in this particular. In the first months of last year I wrote out what I regarded to be a suitable article in the form of a statute, based on the law of Indiana for the same purpose, and gave it to the Jefferson County representative in the legislature, with a promise from him that it would be presented to the House for action in a short time; but he, thinking a medical man would take more interest in the matter and understand it better, himself being a lawyer, handed it over to a doctor member, who, my friend informed me, promised to bring it before the House in a short time. Since that I have heard nothing of it, although I have written the doctor on the subject on two different occasions. I can only account for the doctor's negligence in this particular on the ground that he has abandoned the practice of medicine and turned politician, thereby losing all interest in the welfare of the population of his State.

It would seem to me that every practitioner of medicine should feel a deep interest in the sanitary condition of our people and be glad to be familiar with the birth- and death-rate thereof. This kind of feeling so pervades my mind that sometimes I am apprehensive that I may be regarded by some not so much interested as being somewhat cranky on the subject. But, be this as it may, I think I am acting in accordance with the well-known pride that Kentuckians generally possess.

In a former report I have alluded to the fact that our Auditor's report of the various statistics of Kentucky will compare favorably with that of any other State. In many respects we excel any other State in the Union. In some farm products we stand far ahead. We produce half the tobacco of the country, ninety per cent of the hemp, the best whisky in the world, as well as the finest and fastest horses, and it is said the handsomest women; and this I believe to be true from observation, if I am not too old to be a judge. Now, what citizen of our State is not proud of such statistics? I presume one could not be found. A Kentuckian loves to talk about these things, especially when abroad among strangers; and if feelings of pride enthuse him we can only

regard it as being commendable. But suppose that this Kentuckian abroad should be a physician, and after expatiating on the statistics of his State pertaining to the things we have mentioned, his listener should ask him in regard to the sanitary condition of his people, and want to know something about the birth- and death-rate. Our proud fellow-citizen would now be somewhat nonplused. We can very readily appreciate his feelings. After talking proudly about every thing else concerning his State, he must feel greatly depressed in spirits when compelled to acknowledge, as my friend Dr. Yandell did lately, when called on to testify in a certain intricate case, that he did not know any thing regarding the matter, and did not believe any one else did. But we might say this proud Kentuckian might excuse himself on the ground that he did not take a part in making the laws of the State. And here we are confronted with the old-time saying, "That what's everybody's business is nobody's business;" but we must not endeavor to let ourselves out of a dilemma by any such excuse. What is everybody's business should be regarded by each individual of everybody to be his particular business to assist everybody to do what should be done for the general good.

As before remarked, if any portion of the community should be interested in the welfare of the people it is the medical profession, not in a money sense, but as philanthropists. And I think, if all our medical men would act in concert, we could get a proper law enacted by which we could obtain the necessary statistics pertaining to the sanitary condition of our people, as well as the birth- and death-rate.

Now, gentlemen, when we earnestly consider the question of statistics of a State we must conclude that the public welfare is at least of as much importance as the number of pigs or calves we raise, or the quantity of wheat or corn we produce. We should be equally informed as to the sanitary condition of our people, the increase of population, and their birth- and death-rate. A neglect of our duty in this particular would seem to be retrograding on our part in matters pertaining to sanitation and public health.

Within our own time great advances have been made as it respects this subject. The great minds of Mapother, Southwood Smith, Playfair, Chadwick, and others gave it such impulse that many thought it was of modern origin. But if we revert to ancient history we will find that the welfare of the people, as it respects public health, was a matter of legislative consideration. The Jews had their Mosaic Code, prob-

ably the most ancient on record. The Greeks and Romans, although not like the Jews, making hygiene a part of their religious duties, were far from neglecting it. "The laws of Lycurgus," says Dr. Gairdner, "are not wanting in very pointed enactments on sanitary matters; and the importance attached by all Greek republics to physical culture is too well known to require remark." The Romans appointed physicians as health officers to supervise the welfare of the people in this particular. But during the night of the Dark Ages superstition prevailed over reason, and sanitary science, with other branches of knowledge, slept in a sepulcher of gloom. But now, as darkness has changed to light, the night of ignorance and superstition vanished and reason resumed her throne, we should rejoice at our freedom.

Then let us hope that in the future our people, and especially our profession, may take greater interest in this part of our statistics, and induce our representatives in the legislature to provide proper means for their collection, so that our proud Kentuckian when abroad may not have cause to blush with shame on account of ignorance when questioned in regard to the population of his State. Let us believe in the adage that "Public health is public wealth."

ORELL, KY.

INTUBATION OF THE LARYNX AND ESOPHAGUS.*

BY WM. CHEATHAM, A. B., M. D.

Professor of Ophthalmology, Louisville Medical College.

The history of this operation has been so frequently written that I think it hardly necessary to repeat it here. Its position is so well established I do not believe it debatable. That much has been said against it which has since been proven false no one can deny. That it can take the place of tracheotomy in all cases, its most earnest advocates will not claim. That intubation in laryngeal croup is more successful than tracheotomy I do not think there is any doubt. And I wish to say here that I believe there is but one cause of laryngeal croup, and that is diphtheria. That there are at least three forms of diphtheria, one only having the Krebs-Loeffler bacillus as a cause, is now a well-established fact. That diphtheria is at first a local disease I believe, and believing this, Bourges' description of the disease, "that there are two sets of symptoms, one local, producing 'mechanical' accidents, due to false membrane, the other general, due to poisoning by the diphtheric

*Read at the May meeting of the Kentucky State Medical Society, 1893.

toxine"—that is, when the Krebs-Loeffler bacillus is present—seems to me sufficient.

In considering the subject of intubation I shall refer to it not only in croup of the larynx, but as a relief in stenosis of the larynx from other causes, and also wish to refer to intubation of the esophagus for stricture and carcinoma. When I introduced this operation in Louisville I was not much encouraged by the local profession, and especially when I had but one success in my first fifteen cases. Tracheotomy had been more successful than that; my success since, with that of others who have taken it up, has, I believe, so well established the operation that no one now in that place would think of performing tracheotomy if he could have intubation done.

In 1889 I showed the instruments for intubation in "Great Ormond Street Hospital" for children, in London, where it has been performed many times since with success. In the same year I had the pleasure of lecturing on the subject at Prof. Krause's Polyclinic, in Berlin. The operation is now performed all over the world. Having been brought to perfection in America by an American it was not adopted as readily abroad as it should have been.

As to the instruments needed in this operation, none of them have been brought to the perfection of those made under Dr. O'Dwyer's supervision, except possibly the introducer now used by Dr. Pusey and myself, suggested by Dr. Pusey. In this introducer the instrument is much simplified and much easier cleansed; the tube is dislodged by the front finger of the left hand, so the complicated and difficult-to-clean instrument, found now in the cases of instruments sold by the dealers, will soon be a thing of the past. One undertaking the operation of intubation of the larynx should have several tubes of the different sizes, from the smallest to the adult tube; one gag, two extractors—one short for children, and a larger one for adults; a scale for measuring the tubes, which would be unnecessary if the tubes were numbered; a metal protector for the left finger, or a strip of adhesive plaster (the kind that sticks to itself only) for protection of the finger; a bottle of collodion to seal up all abrasures on the hand, and some carbolic acid or antiseptic tablets for cleansing the hands; some braided silk, as it will not knot when being withdrawn from the tube; a pair of forceps to remove membrane from the larynx, if it should be dislodged by the tube; some nitrite of amyl or nitro-glycerine and whisky with a hypodermic syringe; and a set of tracheotomy instruments. I am sure I

saved the life of one child by having convenient the nitrite of amyl. Quick action was needed, and without hesitancy I poured I do not know how much of the amyl into my mouth, closed the nose of the child, put my mouth to it's, and blew the amyl into its lungs; reaction was prompt. The introduction and removal of the tube in the young is by feeling entirely. In the adult it can be done with the assistance of the laryngeal mirror. In the adult the operation by feeling is more difficult than in the child, as the larynx is so much more difficult to reach with the left forefinger; the same applies to the removal of the tube. Feeding with the tube in position, especially fluids, has to be done with the larynx lower than the chest, so the fluids can not enter the lungs. Two of my successful cases were fed with milk from a rag, the child taking the usual position on the side with the head well over, or on the back with pillows under the shoulder, or the head hanging over the side of the bed. This question of feeding is a very important one, and it is well known that even under the most favorable circumstances it is a fight from the beginning of the disease. The removal of the tube has always been to me much more difficult than its introduction. This has been partly overcome by a method, for the introduction of which I have recently noticed I am given the credit; that is, by pushing the tube out by external pressure from below, making the pressure up and back with the thumb of the left hand, and catching the tube with the forefinger of the right hand introduced into the mouth. So the difficulties attending the operation are disappearing one by one, and the operation is rapidly approaching perfection. It has now progressed so far as to give better results than any other in laryngeal croup in children up to ten years of age, and is as good in those older. The operation, as I stated before, is here to stay, and too much glory can not be given Dr. Joseph O'Dwyer, of New York, who has brought it to such perfection. That it is not an easy operation to perform, and that every one is not capable of performing it, many have found out by experience.

After eight or ten years of age the death-rate is known to be very high, and is accounted for by the knowledge that it must be a very severe type of the disease to obstruct a larynx so large. I have tubed 59 cases, with 24 successful, or a little over 40 per cent. Leaving out my first 15 cases, I have 23 successful in 44, or over 52 per cent.

Intubation is also practicable in stenosis of the larynx, the result of growths of that organ, especially papillomata, as by the presence of the tube the stenosis is relieved, and pressure made upon the growth so as

to cause its absorption. I have now a child about three years old with papilloma of the larynx who has been wearing a tube since September last. The tube has been removed and another introduced about four times in the meantime. The tube in this case was left out six weeks ago, the child's respiration being perfect.

Intubation is also successful in stricture of the larynx, the result of disease or trauma; in these affections we also get good results from the pressure of the tube.

Dr. G. M. Lefferts, of New York, says, in the Medical Record of October 4, 1890: "Confining myself, then, to the question of syphilis alone, intubation certainly offers in a large proportion of instances the simplest and most practical means yet devised of quickly and efficiently relieving the dyspnea of acute laryngeal stenosis, thus avoiding tracheotomy, and for dilating chronic cicatricial stricture in its varying grades and forms with speed and certainty, thus dispensing with the temporary or permanent necessity of a tracheal canula."

Dr. Lefferts had a patient to wear one tube ten months and four days.

I have a patient, forty-five years of age, with paralysis of the abductors of the larynx, who has been wearing a tube several months. In paralysis of the abductors the vocal cords come close together, and the more the patient makes an effort to breathe the closer they approach, thus interfering much with inspiration. The patient now wearing the tube I am sure could not have lived much longer without the relief given her by its introduction; her skin was purple, and she could not sleep but a few moments, yet would fall asleep while talking to any one. One suggestion I wish to make in regard to patients wearing tubes for any length of time, and also those wearing tracheotomy tubes: some little fluid should occasionally be allowed to enter the tube and larynx to excite cough, and while coughing the patient should lie down on the stomach with the chest low to allow any fluid or excretions retained in the lungs to be cleared out. It is a fact that, with either the intubation or the tracheotomy tube in position, the patient not being able to constrict the larynx while coughing can not give the expulsive act enough force to clear out the lungs. The position spoken of above favors this.

Dr. J. Solis Cohen, of Philadelphia, gives most favorable reports of the result of intubation in stricture and cancer of the esophagus. Tubes have been worn for months with most excellent results, especially in cases of stricture. The tubes are of course of different material and differently shaped from those used in the larynx.

RENAL AND VESICAL HEMORRHAGES.*

BY R. A. PRICHARD, M. D.

The average doctor is apt to administer diuretics in all cases of nephritic disease; his mind flies to a medicine reputed to allay genito-urinary irritation, and in most instances he prescribes a damaging medicament. If the hemorrhage be from the bladder, with no known specific cause, it is well to inject into the rectum an enema of starch and laudanum. This will arrest pain, and lessen the desire to micturate. The urine is not to be evacuated by the use of a catheter until voluntary expulsion is impossible or impracticable. If coagula gets in the way of a freely flowing stream, a good-sized metallic catheter will help break up the clot, and favor evacuation of the obstructing collection. In time the coagula becomes disintegrated, and is passed by the urethra. The presumption usually is that the hemorrhage will not be repeated; but if it should be, the use of diuretics can do no good, and may do harm.

Persevere in the local sedative treatment, giving internally pinus canadensis. The pinus does not disturb the stomach, and acts soothingly upon the urinary tracts. Gelsemium is sedative, and at the same time worrying to the stomach. Hyoscyamus does about the same thing, and so does digitalis; hence they do not accomplish much more good than they do harm. Freedom from pain is very important, hence hypodermics of morphine, say a quarter of a grain every six or eight hours, are in demand. The patient is not to be narcotized to stupidity, but is to be given rest and freedom from acute pain.

Should there be pain in a kidney, and a tender tract along the course of the ureter to the bladder, the bleeding is nephritic, yet to be treated much as you would treat hemorrhage from the bladder. The urine is to be scrutinized for cylindrical clots which look verminous; they are casts from the ureters, and indicate that the bleeding is of the kidney. Possibly a nephritic calculus is passing or has scraped the ureter.

There are multiple pathological states to be considered, and all are more or less obscure.

Cancer of the kidney or bladder is to be suspected, though not to the exclusion of less dangerous states. A congestive condition of the renal organs is occasionally accompanied or followed by hemorrhages from one or both kidneys. There is no pressing occasion to test the

urine for sugar or albumen, for hemorrhages rarely hinge upon diabetes or Bright's disease.

A congested state of the lungs has been attended with renal hemorrhages, and the complication has seemingly given relief to the pulmonary oppression. If there be angina pectoris in the combination, nitroglycerine is to be administered. The drug may be administered in capsules if you wish. In Bright's disease—in albuminuria—it is a valuable and potent agent. It disturbs the stomach less than digitalis. Quite often the two agents should be administered in alternation—the digitalis in officinal infusion, one dram at a dose. But if these remedies do not subdue nephritic pain, the hypodermic use of morphine is in demand. Do not let a patient die of pain when a lethal agent is at hand. The passage of a urinary calculus causes such excruciating pain that often the inhalation of chloroform may be utilized. It is better to do some little harm with sedatives than to allow your patient to die of pain. It is easy to say "remove the cause and the pain will cease," much easier than to execute the order. A calculus of the kidney is not easily removed; and a clot of blood in the bladder must be waited upon to some extent. The use of terebinthins as local applications in renal and vesical hemorrhages should not be despised. Turpentine is "homeopathic" in hemorrhagic states.

LOS ANGELES, CAL.

CARE OF UPPER AIR-PASSAGES IN TREATMENT OF SYPHILIS.*

BY E. R. PALMER, M. D.

My purpose to-night is to present to you a short note regarding the importance of careful and frequent inspection and proper treatment of the upper air-passages in syphilitics.

Contrary to a quite common belief and mode of procedure the scientific treatment of syphilis is any thing but simple or stereotyped.

Attention to what at first seem but little things constitute a very important part of the surgeon's duty. He has a great deal more to do than to simply order two years or more of constitutional treatment with a cessation from tobacco and alcohol. Among the other duties that devolve upon him are frequent inspection of the nose, mouth, and

* Read before the Louisville Surgical Society, May 8, 1893. For discussion see page 183.

pharynx. The mere casual search for mucous patches in the latter two will not suffice. On taking charge of the case he should familiarize himself fully with the pre-syphilitic topography of these parts. In so doing it will be a matter of surprise how frequently their condition is found to be a vicious one. Notably is this the case as regards the mouth; scurvy, snags, or a general foul and so insanitary condition being frequently present calling for correction. When possible each patient, unless the mouth be found in an excellent state, should be sent at once to a competent dentist to have his teeth cleansed, filled, etc., and he should be ordered not only a good dentifrice with soft brush and pure castile soap for daily use, but from time to time, when any specific evidences appear, a mouth wash of listerine, zymocide, or the like, used if possible in full strength.

Enlarged or chronically diseased tonsils should be removed, and, chronic non-specific catarrhal conditions of the pharynx being common, these parts must be brought into the best possible condition by local and constitutional treatment. But of vastly more importance is the care of the nares. It is reprehensible in the extreme to wait until bloody discharges or bits of exfoliating turbinated bone tell the story of probably irreparable damage.

It must not be overlooked that while destructive and incurable phases of syphilis usually attack the nares late in syphilis, they are also usually preceded by early and curable troubles that lay the foundation, when overlooked, for the final damage.

On calling last summer at the office of Dr. Taylor, in New York, I was struck with the array of nasal apparatus there. When I remarked upon it, he replied: "If I have any hobby in the world it is the care of the nose in syphilis." A good hint, from which I have since had good profit. His method is free flushing of the parts by means of syringe or douche rather than spray, and that as often as the necessities of each require. He usually employs ordinary salt water, diluted chlorinated water, and other standard remedies, including chlorate of potash.

One object I had in calling your attention to this matter to-night is to urge in such cases, both as an exploratory and as a curative measure, the use with a post-nasal syringe of a combination in equal parts of Dobell's solution and 15 vol. peroxide of hydrogen. When trouble exists, sometimes the discharge of enormous quantities of decomposed muco-pus follows, with a great sense of relief and comfort on the part of the patient. Pain is rarely experienced; and where it is, a one-per-cent

solution of cocaine snuffed from the hollow of the hand suffices for its relief.

While I do not urge this as a *one* remedy in nasal syphilis, I desire to add it as an important combination to the list already recorded. Gummata of the hard palate are usually of a tertiary character. I have recently relieved two such cases without perforation by heroic mercurialization and the application of saturated solution of silver nitrate daily, and had better results than are obtained usually by the mixed or pure iodide treatment.

A case recently under my care illustrates the necessity of close observation in upper air-passage complications. An actress, leading lady of a prominent combination, came to see me with acute aphonia. She was greatly distressed, as she stated a surgeon of Johns Hopkins Hospital had told her her disease was syphilitic in character. She was vehement in her assertions that she had never had syphilis. On examination of her mouth I discovered an enlargement—median of the hard palate—gumma as large as an ordinary grape. I sent her to see Dr. Cheatham, who found no evidence of syphilis in her throat and soon relieved her. She had been sent to me by her manager for treatment, and so stayed some two weeks. I saw her daily, as did Dr. Cheatham, and it was not long before we diagnosed the elevation to be a congenital deformity. The patient has since remained wholly well.

The other doctor diagnosed syphilis, probably from the supposed gumma, not having made, as I learned, a laryngoscopic examination.

LOUISVILLE.

FEES FOR MEDICAL SERVICE TO MILLIONAIRES.—The two physicians who attended Mr. John W. Mackay, the California millionaire, in his recent illness, have sent in bills for \$5,000 and \$7,500, respectively. Mr. Mackay refuses to pay them, on the ground that the sums charged are exorbitant. We do not know the amount of service rendered, but if the rates exceeded the maximum fees, and if an extra sum was added, as is alleged, because Mr. Mackay is a multiple millionaire, our sympathies are with him. A physician has no more right to treble his fees because a man is rich than has a tradesman to treble the price for his wares. There are circumstances, however, when the service rendered is so directly saving of life and suffering, and where the attendance involves so much responsibility both for the life of the patient and the reputation of the surgeon, that it is difficult to say what should be the fee. Ordinary rules and rates do not apply here.

Reports of Societies.

LOUISVILLE SURGICAL SOCIETY.*

Stated Meeting, May 8, 1893, Dr. A. M. Cartledge, President, in the chair.

Dr. W. O. Roberts (Fatty Tumor): This specimen is a fatty tumor which in itself does not amount to much, but the location from which it was taken makes it rather interesting. The patient was fifty-five years of age, and the tumor was first noticed three years ago; it was then quite small and was thought to be an enlarged gland in the carotid triangle of the neck. It has grown gradually. At the time of its removal, ten days ago, it had attained a considerable size and caused a good deal of discomfort from pressure upon structures of the neck. It is the first time I have ever seen a fatty tumor in this locality, and for that reason I report the case. Hemorrhage, which would have been considerable, was controlled with clamp forceps. I was assisted in the operation by Drs. Joe Anderson, Beard, and Block.

DISCUSSION.

Dr. E. R. Palmer: Did the tumor have any effect on the breathing?

Dr. Roberts: It had begun to do so.

The essay of the evening was read by Dr. E. R. Palmer; subject, The Care of Upper Air-passages in Treatment of Syphilis. [See p. 180.]

DISCUSSION.

Dr. Roberts: In regard to peroxide of hydrogen in the nasal douche, I tried this on two cases, and it produced such discomfort that I had to stop it. However, in these cases I used Marchand's peroxide of hydrogen. I have since used the Oakland Company's, which did not produce any of these disagreeable effects. I would like to ask Dr. Palmer if he does not think the douche would answer the same purpose as the post-nasal syringe? I rely chiefly in the management of these upon constitutional treatment.

Dr. Palmer: The thing is to get them to use it. In cases of early syphilis I have removed from the nostrils sometimes a double handful

*Stenographically reported by C. C. Mapes.

of muco-purulent material by throwing the syringe twice full up over the velum palati. I have never seen any inflammatory trouble follow the use of the syringe. I use the Oakland peroxide solely.

Dr. William Cheatham: I remember the case Dr. Palmer refers to very well. I did not believe it was a node or gumma. I saw an article a short time afterward where a gentleman reported a lot of these congenital projections.

I think Dr. Palmer's solution of peroxide a little strong; it is liable to be forced into the middle ear and up into the sinuses. I think that he will find that a 2 or 3 volume will do just as much good and is much safer. Another precaution I would like to call Dr. Palmer's attention to, is that of blowing; if you have the patient to blow, some of the secretion or solution is very liable to get into the middle ear. Always, after using spray, douche, or post-nasal syringe, let them draw it down instead of blow, thus avoiding danger to the ear.

Dr. Roberts asked about the douche: No anterior treatment reaches more than two thirds of the nose. Where a solution is used anteriorly, either with spray or douche, it does not reach over the turbinates, but if you use it posteriorly it does. Men write a great deal about syphilis of the upper air-passages; I think I have but one case now. Syphilis shows about one third the way back in the right nose in this case, which I have relieved by chromic acid. I think it was gumma; the patient had primary lesion four or five years ago. In late syphilis I find cod-liver oil very beneficial.

Dr. A. M. Cartledge: I suppose my experience is like that of most other physicians; I find some cases recover very promptly under treatment, while others are very obstinate. I formerly used nitrate of silver nearly altogether. In the last year or so I have been using gargles or mouth-washes of mercury bichloride, using it as part of the treatment. I think bichloride wash just as a sanitary measure is a good thing. Many of these cases demand other things than iodide of potassium. As a rule I think we neglect the general building up of these people too much. I believe, in the late manifestations of syphilis, quinine, cinchona, cod-liver oil, etc., may be given with excellent results.

Dr. Palmer: I am surprised that Taylor, in his work in Hare's system, objects to the use of the black wash in syphilitic troubles. He says that in private practice it nauseates his patients, but in the Vanderbilt Clinic he gets very fine results from it. I think a great deal of the black wash, and advise its use in suitable cases. It was more to

call attention to the matter of mouth hygiene than any thing else that I prepared the short paper read this evening.

In the matter of cod-liver oil (as most of you know, I taught lung diseases for sixteen years) I believe that benefit may be derived from the administration of cod-liver oil vastly more in late syphilis than in phthisis. I prescribe it nearly every day; there are three or four favorite preparations among the emulsions, and I give them, feeling absolutely certain that beneficial results will follow. My faith has very materially weakened in regard to the iodides; I do not get results from them such as I would like or would expect, considering the reputation they have had.

I want to mention two other cases, in addition to those referred to in the paper, where I have recently relieved gummata of the hard palate by the administration of three to five grains of proto-iodide daily, and daily application of nitrate of silver; both cases were completely cured without any destruction of the bone. One of the patients was a terrible acne subject; had been to Hot Springs twice; he could not take iodide of potassium without its producing very distressing conditions, tumefaction, tormina, and all the other disagreeable symptoms. I gave him cod-liver oil, and he was then able to take the other treatment without any trouble.

The next case was double infection. While he was being treated for tertiary syphilis, contracted in 1885, he got a fresh case. While under treatment for this new syphilis he developed a gumma of the hard palate. He was given four or five grains of proto-iodide daily, and with the application of silver nitrate got entirely well. I do not give iodide of potassium in conjunction with cod-liver oil. I think iodide should be used singly, but my results in its use are not very encouraging, except in brain and bone syphilis. In such cases iodide is indicated sometimes to the Hot Springs extreme; 120 grains three times a day, or even more, will be found very beneficial.

Dr. Cheatham: I would like to call attention to the fact that in some severe cases of secondary syphilis of the tonsils, pharynx, and inside of cheeks, constitutional treatment appears to have but little effect until the above lesions are relieved by local treatment. I use in such cases the "black wash" or hydrogen peroxide (Oakland Co.) 10 vol. 6 ounces, glycerine 2 ounces, hydrarg. bichloride 1 grain, locally. I do not know how to explain this, but know it to be a fact.

Dr. H. H. Grant: I would like to ask Dr. Palmer if he uses mercury hypodermatically in the treatment of syphilis?

Dr. Palmer: I have never employed mercury hypodermatically. I think injections might be used simply for their local effect. For instance, some men inject gummata and nodes in the treatment of syphilis with the view of getting the local effect of the agent. It has never become a part of the treatment in this country. It is exceedingly painful and has not done the work it was claimed it would do. I think this is one reason why the hypodermatic use of mercury has not become general. It was claimed that by this means, in a three-months' course of injection, syphilis could be eradicated from the system. I do not believe this will ever be the case; you must treat your patient over a considerable period of time, no matter what agent you use or the manner of introduction.

Dr. Grant: Do you not think that the good effect derived from the administration of cod-liver oil is owing to its constructive powers aiding the constitution to avert or overcome the tertiary manifestations, thus rendering iodide unnecessary?

Dr. Palmer: I do not see how we can well explain the wonderful results obtained by the use of cod-liver oil. I hardly think it can be explained by the small amount of iodide it contains.

Dr. Cartledge: Do you not think that mercury when applied to the local manifestation of syphilis has a local specific effect?

Dr. Palmer: Unquestionably it has. The action of mercury is as a solvent of the neoplasm; and this is where I would favor injection, in pronounced lesions, the injection of the gummata to get the local effect of the mercury. The point I wished particularly to emphasize is the care of the mouth; that it is not sufficient to look into the mouth for mucous patches, etc. You would be surprised at the number of people that present with the most horrible mouths. Scurvy is a very common condition; teeth loose, breath foul, gums bleeding, and all those other conditions that make the mouth look more like a cesspool than the sweet, clean organ that it should be. Another point I want to emphasize is, that the physician should familiarize himself with the pre-syphilitic topography of the case.

In the case of the actress with the growth in her mouth; if her mouth had been carefully examined previously she would have been familiar with the true nature of the trouble there. She was not even able to tell how long this growth had been present.

In this connection I would like to mention that I saw to-day a lady who had the change of life ten years ago, a wonderfully well-preserved

woman, with the two tonsils as large as you will see in very much younger subjects; two immense tonsils almost meeting in the pharynx. I was laboring under the impression that the tonsil atrophied in old patients.

Dr. Cheatham: Such conditions are not common.

Dr. A. M. Vance (Partial Thyroidectomy): I would like to make a continued report. At the last meeting of this Society I presented a specimen consisting of a portion of thyroid gland removed a few days previously. At that time I read a letter from Dr. Louis Frank, written me after he had made a careful microscopical examination of the growth, in which he pronounced it thyroid gland. You will remember at that time there was some doubt expressed by one or two members as to the nature of the tumor; that is, whether it was really thyroid tissue. I have since had it examined by several other microscopists, and they all agree with the report made by Dr. Frank. I will read their several letters, also a short report from the New York Medical Journal, and a quotation from the American Text-Book of Surgery, bearing on the question:

PARATHYROID GLANDS IN MAN.—At a meeting of the Paris Medical Society of the Hospitals, held on March 17th, reported in the *Union Medicale* for March 21st, Dr. Chantemesse and Dr. Marie described some little glandular organs found in the neighborhood of the thyroid gland in man, and confirmed Sandstrom's description of parathyroid glands. They form two groups, one of which, the more important, is situated at the level of the point of penetration of the inferior thyroid artery. This group consists of two or three glandules, none of them larger than a lentil, round, ovoid, or kidney-shaped. The other group, generally less voluminous, is at the level of the point of penetration of the superior thyroid artery. These little glands are free or surrounded with connective tissue and provided with a minute vascular pedicle. Their structure is very different from that of lymphatic ganglia. They are divided into lobules by a connective-tissue stroma, and are traversed by numerous capillary vessels. The lobules are formed of little cells sometimes disposed irregularly, sometimes arranged in a circle, the periphery of which is bordered with little cubical cells and the center filled with irregularly disposed elements. Occasionally the tubes of epithelial cells may be made out, and at the periphery of the glands there are often to be seen little rounded masses, the central part of which contains a material having a colloid appearance. Stress was laid on the fact that these glandules were situated externally to the capsule of the thyroid gland, and it was urged that they be left in cases of thyroidectomy, for they were capable of a compensatory function analogous to that of the pituitary gland.—*New York Medical Journal.*

The body is quite likely to be accompanied by accessory masses of similar tissue, which may be connected with it or may lie behind the trachea, or beneath the base of the tongue, or elsewhere about the middle or anterior portions.—*American Text-Book of Surgery.*

DR. A. M. VANCE: I agree with Dr. Frank's statement, having made a microscopic examination of tissue, and would like to add that I believe it to be not only thyroid-gland tissue, but a goitre. WM. VISSMAN, M. D.

DEAR DOCTOR VANCE: I was requested by Dr. Rodman to examine a piece of tissue unaccompanied by clinical history, etc. I did so, and after examining ten or twelve sections reported it as thyroid tissue. I presume this is the same tissue examined by Drs. Frank and Vissman, and, if so, I concur in their diagnosis. H. M. GOODMAN, M. D.

DEAR DOCTOR VANCE: At your request I have examined a section of the tissue above described, and find it to present all the characteristics of thyroid tissue. H. A. COTTELL, M. D.

DEAR DOCTOR VANCE: Macroscopically and microscopically I think the tissue sent me by you to be a thyroid gland. JOHN L. HOWARD, M. D.

DEAR DOCTOR: Just coming home I found your note requesting me to give you my statement in regard to the specimen examined for Dr. Rodman, and I gladly do so, as I have done at the time to him. The piece of tissue handed to me by Dr. Rodman was partly dried at the outer surface and consisted of two sorts of tissue to the naked eye, one grayish and glistening, the other, a small nodule at the periphery, a yellowish-white firmer tissue.

Microscopic examination shows the tissue to be made up of gland-acini, varying in size from 1-25 to 1-500 inch, irregular in outline, separated from one another by a delicate fibrous wall, and lined with roundish nucleated cells somewhat larger than the ordinary lymph corpuscles. In some of the larger acini the lining cells are flattened by compression of a clear homogeneous refractive substance filling the acini (colloid material); some few of the acini are filled with an organized tissue made up of a delicate connective tissue; some others have a yellowish-brown pigment lying within the colloid material.

The above mentioned yellowish-white portion is made up of densely packed alveoli, which are filled partly with colloid material, but the majority with densely crowded cells of the same type as those lining the wall. The stroma is supplied with a moderate amount of small blood-vessels.

As to the *resume*: I have not the least hesitation or the slightest doubt to state, as I have done to my friend Dr. Rodman, that the specimen in question is a piece of thyroid gland in a state of (very common in this structure) colloid degeneration, or, as you find it named by German pathologists, struma colloides. C. WEIDNER.

Dr. Frank has made several sections of the growth, which I have had him bring here this evening, and would be glad to have you examine them through the microscope, also compare them with other specimens of thyroid tissue.

Dr. W. L. Rodman: I wish to add a word in regard to Dr. Weidner's opinion. Dr. Vance was kind enough to give me a portion of the specimen; I had it in my buggy, and in driving down town met Dr. Weidner, who said he would be very glad to examine it. He made an examination and made the report to me verbally that he has in writing to Dr. Vance. I take pleasure in stating that Dr. Weidner further said he was not certain, but at one point in the section he made there seemed to be cells of a sarcomatous nature. I do not mean to quote the doctor as saying that it was necessarily sarcomatous degeneration of the thyroid, but he found cells looking very much like sarcoma cells. I stated at the last meeting that if this was thyroid tissue, I was satisfied that it was an accessory thyroid that occurs occasionally at different points in the neck, sometimes inside the larynx and trachea, and when they do occur they are subject to the same enlargements as the thyroid-cystic degeneration and fibrous bronchocele.

From the unanimity of the report made by the microscopists, I am satisfied that this must be thyroid tissue. I am still under the impression, however, that it is an enlarged accessory thyroid, as the isthmus is very infrequently the seat of goitre, which nearly always affects the two lobes, preferably the right. Hypertrophy of the isthmus is very infrequent. In a paper that I am now preparing, which will be read at the meeting of the Kentucky State Medical Society next Thursday morning, I take up diseases of the thyroid as well as other diseases of the neck. I have gone over the literature very carefully and am therefore in position to speak advisedly upon the subject. Benign solid growths practically do not affect the thyroid gland, the only one being the fibrous bronchocele or hypertrophy of the gland. Cystic degeneration is frequent. As to malignant growths, Kaufman, in an elaborate paper on the subject, was able to collect only twenty-one cases of carcinoma affecting the thyroid, and seven cases of sarcoma. So I think I was right in stating that benign growths of the thyroid are practically unknown, and that malignant growths are very rarely found, so rarely that I doubt if any member present has ever seen one.

Dr. Louis Frank (visiting): I was asked by Dr. Vance to bring some sections of the specimen handed me by him here to-night to demon-

strate the correctness of my diagnosis. His report from the other microscopists of the city was entirely unsolicited by me. I intend to stand on the report I have already made. Some one has mentioned the short time consumed by me in making an examination of this tumor; I will state that as the specimen was fresh no time was required further than to make a few sections of the growth and mount them for examination, probably ten or fifteen minutes.

Possibly I misunderstood Dr. Rodman in saying that non-malignant growths of the thyroid were very infrequent. From my reading (and I have looked over two or three books on pathology since this tumor was sent to me) I find that cystic growths of the thyroid, what he ordinarily term struma, are quite common. I agree with Dr. Rodman that malignant growths of the thyroid are very rare, comparatively few cases being on record. Benign growths, though, are very frequent, being either of the cystic variety or being fibroid in character; the latter variety being usually of changes following hemorrhage of the cystic tumors.

Dr. H. M. Goodman (visiting): I have very little to add to the foregoing remarks, except to define my position in connection with the examination of the specimen. I worked under adverse circumstances. I knew nothing about the case; a piece of tissue being handed me by one of my colleagues at the University, with the request that I examine and report upon it. I remarked at the time that it was a very difficult thing to do in the absence of any clinical history; but as the tissue seemed to be tolerably hard and firm I immediately imbedded it in celloidin, and made a few sections and proceeded to examine it. The first section showed thyroid tissue with increased amount of colloid material in the sacs of the tissues. I am glad for once the microscopists of the city seem to be agreed, and certainly I think the diagnosis is absolutely settled. I will add, however, that in sending the report to Dr. Rodman I made the diagnosis of colloid struma.

Dr. Frank: I would also like to say that it is only by microscopical examination that we are able to recognize certain tissue macroscopically. It is the microscope that renders us able to know certain tissues, and that has by analogous structures enabled us to say what they are when we next see them. Were it not for the microscope we would never be able to recognize carcinoma or any other growths macroscopically.

Concerning the point made by Dr. Goodman in regard to the clinical history, the specimen was handed to me with no history what-

ever, except that the tumor was removed from the neck, consequently the question of clinical history did not figure in my diagnosis. You can not always rely upon clinical history for diagnosis.

Dr. W. O. Roberts (Rib Resection for Empyema): I will report a case I operated upon at the University Clinic last Tuesday morning. A man thirty-five years of age sixteen years ago had what was said to be pneumonia of the right side, and had never been well since. Five years ago a large swelling appeared just above the edge of the cartilage, on the right side, and it was finally opened, discharging very profusely, and has been discharging freely ever since. Upon examination I found the left side of the chest enlarged and the right side perfectly flat and dull clear up to the point of the scapula. I made an incision down to the seventh rib on a line with the posterior diameter of the axillary space; found the ribs so close together that I could not get any thing scarcely between them. I then resected a portion of the seventh rib, removing a piece probably about two inches in length. I then opened the chest, and I think that the foulest pus that I have ever smelled in my life came out. There must have been at least a pint of it, if not more. I inserted a large drainage-tube without washing out the chest, emptying it as thoroughly as I could by changing the position of the patient, and sent him the Sts. Mary and Elizabeth's Hospital. He has gotten along without an untoward symptom, and now the original opening is almost entirely closed; nothing comes out of it.

I report the case as being of interest because of the fact that this condition of empyema has lasted such a length of time. He dates it back sixteen years; has never been able to breathe well on that side since the attack of pneumonia.

DISCUSSION.

Dr. Vance: I would like to ask Dr. Roberts why he did not wash out the chest?

Dr. Roberts: Because of the fact that a number of sudden deaths have resulted from washing out the sac in cases of pyemia, especially cases wherein the pyemia was on the left side.

Dr. Cartledge: I hope a continued report will be made of this case; I do not think the man will get well. A lung compressed by an accumulation of pus for sixteen years will not get well as a rule with the resection of $1\frac{1}{2}$ to 2 inches of rib. The case is of such long standing

there is evidently a quantity of old fibrous tissue existing, and I do not believe there will be sufficient lung expansion to fill the cavity. I think there will be a discharging sinus requiring a more extensive operation. That has been my experience. The lung will not expand, and you will have to take out a section of two or three ribs, and break up adhesions that bind the lung down.

Dr. Roberts: This is the second case I have had wherein this offensive pus existed. Both of them were operated upon at the University Clinic. The first case was several years ago. The man had been shot, the ball entering the upper part of the right side of the chest, between the third and fourth ribs, and had been discharging for something over a year; whenever he would lie down the pus would run out through the opening. I removed a section of the seventh rib, and such offensive pus escaped that almost all the students left the lecture room. Referring to what Dr. Cartledge has said about the case just reported, I made the same remark at the time of the operation. However, I thought it was best to try it with the resection of one rib, and if I failed to get closure, then do the operation he refers to.

I saw, in Edinburgh in 1886, a case that had been operated upon by Annandale for empyema which had existed for years, and it seemed to me that he removed the greater part of one side of the thorax. He made an incision very low down and removed fully four inches of the tenth rib, a little less of the next, and so on until the apex reached about the third rib. He told me he had operated on several cases in that way and had gotten excellent results.

Dr. Cartledge: Do you not think the odor, where the empyema has been the result of original pneumonia, is because of the fact that air has been introduced from the lung? I have seen several cases of this kind.

Dr. Roberts: I am satisfied that there was communication with the lung in this case. Before the operation this man expectorated large quantities of pus that looked tubercular in character. I am very sorry that I did not have a microscopical examination made of it before this meeting. Since the operation expectoration has diminished very much. One peculiarity about this patient is that he has the most marked "club fingers" that I ever saw.

Dr. Vance (Empyema: Resection of Rib without Anesthesia): I would like to mention a case of empyema that I saw the other day.

I was called by Drs. Rudell and Evans to see a little boy who had been sick for five weeks, beginning with pneumonia and ending up with what was supposed to be pleurisy of large proportions. He remained on his right side with the arm extended above his head; had been in this condition for about two weeks, and unable to breathe comfortably in any other position. He was unable to turn over, and all the windows had to be kept open in order that he might get sufficient air. We first gave him some whisky and a hypodermic injection of nitro-glycerine, which improved his forces a little, and I found the whole right lung dull. I inserted an aspirator needle and drew off about an ounce of pus, then the needle became obstructed. I then determined to open the chest without any anesthesia. I made an incision fully three inches long and inserted two large-sized drainage-tubes; about a gallon of pus escaped, much of it being caseous in nature. As soon as about half of the pus was removed, the boy became very cheery and seemed much better.

The point of interest in the case is that the prolonged pressure seemed to have produced complete anesthesia of the whole side. I would have washed out the cavity had it not been for the fact that the boy was so much exhausted that I could not.

DISCUSSION.

Dr. Cartledge: I do not think we are justified in taking the additional risk in washing out the chest in these cases. In the first place you have a large purulent sac that can not be thoroughly cleansed by irrigation, and I think the attempt is attended with danger. If it were possible to render this whole surface aseptic then we might afford to take the additional risk. No matter how thoroughly you empty an empyema sac, when the dressings are changed you will find them saturated with pus. I believe the best plan is to introduce the shortest drainage-tube that will reach the cavity, not attempting to get to the bottom, then apply an antiseptic dressing and let the drainage take care of itself. In my opinion we will shortly have an entirely new pathology of empyema. Pleuritic effusion becoming purulent simply means the introduction of the infection through the lung; that most of these cases of pleuritic effusion follow as a result of pneumonia, is beyond question. It is a well-known fact that in the tuberculous variety, no matter what means of drainage is employed, the patient usually dies.

JAMES S. CHENOWETH, M. D., *Secretary.*

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.*

Stated Meeting, June 9, 1893, Dr. T. L. McDermott, President, in the chair.

Dr. A. M. Vance (Syphilis Ignorans): I first saw this gentleman two years ago, at which time he had a suppurating condition of the left elbow joint following incision of the joint by Dr. Sloan, of New Albany, Ind.; the patient also had a number of suppurating points about the body, one in each armpit, and I think one upon the thigh. He was considerably more run down generally at that time than he is now, and I took it to be a case of syphilis ignorans, he not knowing of having had any primary lesion. I put him upon anti-syphilitic treatment, which was followed by no improvement. I then gave him a constructive line of treatment; this was followed by some improvement in his general health, but there was no change for the better in the suppurating condition. After about a year the right elbow became affected, the armpits never healed, and I then put him in the St. Joseph Infirmary, and scraped out every place that was in a condition of suppuration or open. At that time the elbow was perfectly flail-like in its action, no power at all, but since the operation he has gotten considerable power. I have been very much interested in the case, because I could not determine just what the diathesis was; I do not think it is tuberculous. I have always had the suspicion that it is specific, but there was no improvement under the usual active treatment by the various methods; mercury was given first; afterward large doses of iodide of potassium. An immense amount of broken down material was scraped away, and there has been considerable improvement in the last year. At no time during this period has he been compelled to quit his work, except for two months, when I advised him to quit and go to the country. There is absolutely no history on his part of a primary sore, and no history of tuberculosis in the family.

DISCUSSION.

Dr. E. R. Palmer: I do not think Dr. Vance's reasoning that because the patient is not emaciated is against the idea of tuberculous trouble. I often see tuberculous glands of the groin in persons of a lymphatic temperament who are apparently well nourished and in robust health.

Dr. Wm. Bailey: Have the discharges ever been examined microscopically?

Dr. Vance: No.

*Stenographically reported by C. C. Mapes.

Dr. T. L. McDermott: I have a case under observation at the present time; whether it is similar or dissimilar I can not say. I have had two cases of multiple abscess, whether specific or non-specific I do not know, one of which was extremely interesting. He had been treated by many of the most eminent physicians of Louisville, including Drs. Cowling, Crow, and Yandell. Dr. Frerick had made an incision and scraped out the abscesses, also removing several pieces of bone. This patient had abscesses upon different parts of the body at different times. I was taken to see this man, and prescribed elixir iodo-bromid calcium comp., not with the idea, however, that it would particularly benefit him, as it was strictly a surgical case in which I was not interested. I was greatly surprised about two months afterward to see the patient get out of a buggy and hobble into my office on crutches, after he had been in bed about a year, after he had been to Europe and had consulted some of the most eminent surgeons there, and spent a fortune in doctors' bills in his efforts to get relief. He continued to improve, and eventually became entirely well, not having had an abscess since. Whether there was any virtue in the medicine, or whether the time had simply come when nature had removed the cause of the trouble, I am unable to say. I have another similar case now. Dr. Roberts has seen the patient with me, and I am sorry he is not here to-night. Some of the joints have become ankylosed as the result of abscesses, and abscesses have also appeared in other parts of the body. We can not find any specific history. I have put him upon the same medicine, and although he is an aged man and broken down the abscesses are healing. In the first case I did not believe the abscesses due to hypodermic injections.

Dr. A. M. Cartledge; This does not have the appearance of tuberculous trouble to me, and I am not inclined to look upon it as tuberculous in character. I think it is probably syphilitic.

Dr. Vance: I saw the case Dr. McDermott speaks of (first case), and I think one reason the abscesses never healed was owing to the hypodermic injections given by one of the physicians who treated him; certainly the abscess I saw was due to an unclean hypodermic.

Dr. Vance (Pathological Specimens: Incarcerated Testicle; Strangulated Hernia; Operation.): 1. This specimen is a testicle removed some time ago; my reason for not reporting the case earlier is that I have not seen Dr. Irwin present at any of the recent meetings, and as he was connected with the case I have waited until he attended one of

the meetings. The patient was a man sixty-two years of age, Irish; and a great many years ago, when he first came to this country, he gave the history of pain in the region of the right groin to Dr. Coleman Rogers, who advised him to wear a truss in anticipation of a hernia. Dr. Irwin was the attending physician in the case for some time prior to the incarceration of this hernia, which took place the day I was called. At eleven o'clock Dr. Irwin was called, and found a large hernia of the right side descended, and could discover this testicle in the lower portion of it. After some difficulty he reduced the whole mass, and told the patient to hold his hand on the ring until he (the doctor) could go after a truss. When he returned a smaller mass was present at the site of the hernia, which he could not reduce completely, though it seemed to be easy to make it less in bulk. I saw the patient the same night at eight o'clock. We put him to bed, and advised rest until the next day. There were no active symptoms of strangulation or of obstruction at that time, and we advised him to call us in the night if he had any trouble. He was a very eccentric man, and did not call us during the night, though we learned he complained of severe pain. We saw him at nine o'clock the next morning, and from the aggravated symptoms we decided there was obstruction, and advised immediate operation, which was consented to; but he would not go to the infirmary, insisting that the operation be performed at his home. We opened the sac, and found nothing but serum in it; quite a quantity of fluid also came from the cavity through the hernial opening. I enlarged the opening, practically making a laparotomy of it, and found that a coil of intestine, probably eight or ten inches, was strangulated, the strangulation being produced by slipping of the gut through the opening between a band and the testicle. The testicle was in the abdomen with this coil of intestine. The intestine was quite red, though after relief of the constriction it returned to normal color. I removed the testicle, and did a radical operation for the hernia. The man further showed his eccentricity by driving away the attendants we placed over him until we could get a professional nurse, getting up and walking about the room, getting on a vessel and having an evacuation of the bowels, etc. On our next visit we found him in collapse, and he died at midnight same day of the operation. I take it that, owing to his having gotten up and moved about, the ligature slipped, when hemorrhage took place, or there was some other cause for the great shock, as the operation was very satisfactory, and it seemed that the man had every chance of recovery. No *post-mortem* was held.

2. (Incarcerated Testicle; Hernia; Operation.) This testicle was removed from a boy ten years of age for a condition similar to the case just reported without strangulation. The testicle was removed, and radical operation done for the hernia, and the boy made a good recovery.

3. (Sarcoma of Head of Tibia; Amputation.) Here is a very interesting specimen to me. The patient was a girl about fifteen years of age, a robust, healthy-looking subject, who had the first symptom of trouble about the knee-joint March 1st last. I saw her a week ago, with Dr. Krim. There was a large tumor occupying the inner side of the leg, beginning at the epiphyseal line of the tibia and extending down several inches, with history of having rapidly grown. There was no elevation of temperature, and the only trouble experienced was pain of an acute character; there was no fluctuation in the tumor. I was of the opinion that it was a rapidly growing sarcoma of the head of the tibia, and advised an incision, and if this was proven to be the case, or if there were other conditions to prevent conservative treatment, to amputate. After some procrastination incision was consented to, Dr. Yandell having seen the case in the meantime and agreeing with me in the procedure. I made an incision and found the periosteal structures very thick, the bone completely denuded, and the whole interior occupied by a soft, mushy mass. This thinning out had taken place so thoroughly that spontaneous rupture of the tibia might have occurred without any great effort. After removing the mass, and finding that the tibia was involved for fully six inches, I amputated the leg just above the knee. The patient has done well since the operation. Microscopical examination (by Dr. Frank) proves the trouble to be large round-cell sarcoma.

4. (Removal of Breast for Tuberculous Condition.) The last specimen is the breast of a woman twenty-five years of age, which I removed for tuberculous condition. She gave birth to a child two years ago, and an abscess occurred and has remained open constantly; that is, whenever one opening would close it would re-open at another nodule, irrespective of the former sinus. You will notice that there are a number of nodules occupying the breast. Recovery has been uneventful, except that the patient had secondary hemorrhage.

DISCUSSION.

Dr. J. W. Irwin: Referring to the first case reported by Dr. Vance: I think it is proper that I should make a statement, owing to some

misunderstanding that has arisen as to the conditions which were operative in causing this man's death. I refer to Mr. J. D. O'Leary. He was a rather singular gentleman; he had been under my care for some months for another trouble. Dr. Bailey saw him once in consultation with me while he was suffering from an affection of the bowels. I discovered two weeks before his death that he had a hernia, and advised him to wear a truss. He would not be persuaded that a truss was necessary, from the fact that he said he had had the hernia all his life, and had never worn "one of those things;" that the hernia came out during the day and went in at night. I assured him that all forms of herniæ were dangerous; that some time the bowel would come out and could not be replaced; that this was the rule. The hernia might come out a great many times and be reduced, but would eventually come out once too often. He insisted that he would not wear a truss. When the rupture took place, I can not say, but it must have been the night before I saw him. I saw him at eleven o'clock the day before he died, and discovered the hernial protrusion. He was in great agony, with all the symptoms of gastric pain, etc. I found a protrusion the size of a double fist, a great part of which was serous. After considerable trouble I was able to reduce it completely, and after reduction he was entirely relieved of pain. I left him lying flat on his back on a couch, and instructed him to hold his finger over the opening to prevent the bowels slipping out again, while I procured a proper truss. He still insisted that he would not wear a truss, but I left to get one, and soon afterward returned to learn that he had gotten up and walked about the room, removing his finger from the opening, when the hernia came out again, but not to the same extent as before. I found him again in great pain and tried to reduce the hernia, but it was impossible to do so the second time. I then suggested that Dr. Vance be called, which was done, and we made another effort to reduce it. We finally came to the conclusion that the obstruction was due to a retained testicle in the canal, preventing reduction. In fact, the diagnosis made by Dr. Vance and myself was so accurate that after the operation we found exactly the condition existing that we had stated would be found. The operation I want to speak of as being one of the most cleanly and at the same time one of the most conservative that I have ever seen. It would be safe to say that Dr. Vance removed at least two feet of the intestine, or more, through the opening before he relieved the constriction. He made quite a large opening, really a laparotomy. I do not believe

the patient lost in all over half a teaspoonful of blood, the operation was done so carefully and so well. The patient did well after the operation as long as he remained in bed, but tried to persuade all of us, even Father Brady, the priest, that he did not need a nurse. He further said that he had decided not to allow a nurse to be employed, and that he knew what he was talking about, and would show us that he would have his own way just as he had refused to go to the infirmary to be operated upon. He afterward drove Dr. Rice away, who had been left there to nurse him for a short time, telling him, I believe, that he did not need his services any longer. Mr. Faulds was then allowed to remain with the patient until I could return with a trained nurse which I had been looking for and had in view. The patient, in order to show that he did not need a trained nurse, got out of bed, had an evacuation of the bowels, and walked over to the window, sat down in a chair and looked out, went back to bed and soon after got up again. When we called at five o'clock, or a little after, we found him, as Dr. Vance has said, in collapse, and ten minutes before twelve o'clock he died. There was nothing in the case up to the time he got up and walked about that would indicate anything else than that he would make a good recovery. I think his death was not due to the operation at all, but believe it was due wholly to disobedience. I told the priest this at the time, and he agreed with me, because he said the patient was a man self-willed; though gentle in his manner, he was determined to have his own way when he could. In this instance he did have his own way and he died.

Dr. Cartledge: The character of the obstruction makes the case a very interesting one to me. It only proves that in these old cases of hernia where there is an undescended testicle it is impossible to tell the character of the obstruction until operation is performed.

The tibia case is also one of extreme interest. But for the microscopist's revelations, I should be inclined to look upon the case as one of osteitis with its starting point at the head of the tibia. I believe that this, like a great many of the cases we formerly looked upon as tuberculous, might be secondary osteitis grafted upon an osteo-sarcoma. In other words, the trouble being originally sarcomatous in character, we ought to have more of them examined by the microscope.

Dr. Vance: My idea of rapidly growing sarcoma was based upon the fact that the whole thing grew in three months; twelve weeks ago the patient was perfectly well, no fever, and while the pain was

severe there was no evidence of fluid or breaking down. Very little fluid was found at the operation, and this was probably pus or some product of the sarcoma.

Dr. Cartledge (Peculiar Case of Appendicitis): No. 1. Last Tuesday evening at eight o'clock I was called to see a patient in consultation with a physician who gave the following short history of the case: Sunday morning he was called to see a boy who was taken with pain in the abdomen and diarrhea, getting up very often, straining and having some small fecal evacuations; vomiting came on Sunday evening, which he said was uncontrollable by all ordinary means. Sunday evening he concluded that he would try ten grains of calomel; this quantity was given the patient, which arrested the vomiting. On Monday morning he again visited the patient; some little nausea was present, and slight tendency to vomit. He tried bismuth and carbonate of soda, etc., and during the day, Monday, he resorted again to the use of calomel with Dover's powder, which put the patient to rest again. On Monday three injections of water and glycerine were given, which failed to move the bowels. Tuesday morning the temperature was 102° F., abdomen considerably swollen, and he ordered some salts; vomiting continued, and another injection—a very high enema—was given without any result. On Tuesday evening he came to me with the statement that he had just left the patient with a pulse of 150, persistent vomiting, with an incessant desire to get up at stool. I told him I thought it was a case of intussusception, from the history given. I saw the patient about eight o'clock, found the abdomen greatly distended, pulse not as rapid as stated. I made it 132, and the boy's condition was indeed a very grave one. Vomiting was projectile and stercoraceous in character, and I gave it as my opinion that it was probably a case of intussusception, and advised immediate section. I returned to the city to get my instruments to do a laparotomy, and at twelve o'clock the operation was performed. When the peritoneal sac was opened a great amount of fetid pus was evacuated; it welled up as soon as the incision was made and seemed to originate in the right iliac fossa. The intestines everywhere were matted together and inflated with gas; each loop that came out showed evidence of adhesion to the loop that came in contact with it. Peritonitis was advanced. I found a mass in the right iliac fossa of considerable resistance, and upon drawing it up discovered that it was a portion of intestine constricted as though a band had been passed around it. After working in this region for some time I fished

up this little enterolith, and soon found the vermiform appendix which had ruptured, showing that the original cause of the trouble was in the appendix. The appendix and this enterolith were carefully removed. Evidently the appendix had ruptured early in the attack, and nature had thrown out a wall of lymph as a protection against infection of the general peritoneum; then this band of omentum had produced secondary obstruction as well as the original peritonitis. Several gallons of water were used in irrigation, and I determined if I had another case of diffuse advanced peritonitis I would put in three drainage-tubes; one in the right iliac fossa, one in the left and another in the center. Three were used in this case; drainage was profuse. The patient was placed in bed in fairly good condition, but died the following day at twelve o'clock. I think the case an interesting one, illustrating another phase of the appendicitis subject. It seems that there is a never-ceasing line of complications in these cases. Here was a typical history of intussusception, barring the tumor, which we were unable to discover owing to the tympanites, when the facts in the case prove it to be appendicitis with rupture and an enterolith in the cavity.

(Appendicitis): No. 2. This is another vermiform appendix removed from a patient about the same age as the one just reported; operation done eight weeks ago. The patient was thought to have typhoid fever; he had a well-defined tumor in the right iliac fossa. I operated without opening the peritoneal cavity; found about half a teacupful of pus. The cavity felt quite smooth at first, but in putting my hand down to the bottom of the pus cavity, I found the appendix and discovered that it had ruptured, the opening being a very small one. I made a little traction on it, passed a ligature around and tied it off. The boy made an uninterrupted recovery, and was on the streets in twelve days entirely well.

(Amputation of Leg): No. 3. Here is a specimen of extreme interest to me, being some blood-vessels removed yesterday afternoon. Dr. Vance assisted in the operation. I was called yesterday afternoon to see a young German, of powerful physique, with this history: Last Monday, while at work throwing beer-kegs upon his wagon, he was seized with numbness of the right leg, almost unable to stand up, and suffered with burning sensations in the bottoms of his feet. A physician was called and thought it was paralysis, and he was treated with this idea until I saw him yesterday. I found a German, about twenty-four years of age, of enormous physical development; the leg was cold and

lifeless from about four and one half inches below the popliteal space down; no circulation at all; there was already discoloration and evidences of gangrene taking place. The posterior surface of the leg had a peculiar feeling, indicating possible rupture of the tibial. I examined the heart, and it was a peculiar one. No valvular murmur could be detected, yet it was a very restless and irritable heart. There were no evidences of fever; temperature 99° F. There were no indications of a rheumatic condition of the heart, though he gave the history of having suffered a severe attack of rheumatism in early life. From the fact that gangrene had already begun, and the apparent lifeless condition of the limb, it was amputated between the knee-joint and the thigh. We found very little blood even after the esmarch was removed. Another strange thing was that the femorals did not pulsate either before or after operation. After getting the patient to bed Dr. Vance and myself opened the leg posteriorly, and found, just at the junction of the tibials, a thrombus, although in slitting up the vessels along the posterior part of the leg we did not find any thing looking like an embolus, but just these little casts which had obstructed the posterior tibial. The vessels seemed to be thickened on that side, and the question is whether it was an embolus from the heart, primarily, or whether an endarteritis causing local thrombus. Another question is owing to absence of pulsation of the femoral, whether there is not a higher obstruction in the vessel, and the patient will have the same trouble further up. His temperature this morning was 102° F.; to-night it is 100° F., pulse 88, and patient resting comfortably.

(Second Operation for Carcinoma of the Breast): No. 4. The next specimen is a tumor of the breast removed to-day from a woman fifty-five years of age. One year ago this patient was operated upon for tumor of the breast, and recurrence was very speedy in the line of incision. I take it that originally there were no enlarged lymphatics in the axillary region, as the axilla was not opened at the original operation; in fact there was very little evidence of axillary enlargement, but at the operation to-day there were several enlarged glands in the axilla. I do not think all the gland was removed originally. In the operation to-day the axilla was thoroughly cleaned out and all suspicious tissue removed.

I report the case especially from the fact that I believe I removed more skin than I have taken out in the removal of any breast; nearly the whole of the pectoralis major muscle was removed, as it was all

included in the tumor. So much skin was taken away that of course no effort could be made at approximation. I did insert a few sutures, but the majority of the wound was left to heal by granulation, and will have to be treated as an open wound. Dr. Vissman was present at the operation, and with the microscope made several rapid sections of the skin in order to determine when sufficient was removed to get beyond the malignant trouble. This method is practiced largely in Germany, and I believe the microscope can be used in this way to good advantage. The patient reacted very nicely; pulse 100 at close of operation. The trouble was pronounced by Dr. Vissman carcinoma.

Dr. Cartledge (Tumor in Epigastric Region): You will remember this patient was before this Society about four weeks ago; was examined by several of the members present on account of a tumor in the epigastric region. Several thought the trouble a distended gall-bladder, others abscess of the liver. After making an examination at that time I stated that I did not think it was abscess of the liver. The next day I made a further examination, and came to the conclusion that it was a cyst of the pancreas. The day following I performed a laparotomy, following out the idea of pancreatic cyst, making my incision in the median line. After investigating through the incision I found the case to be unquestionably one of abscess of the liver, and about a half gallon of pus was evacuated. I cleaned the cavity very thoroughly and inserted a very long drainage-tube, after packing the cavity with gauze. The patient has made an uninterrupted recovery; the liver is now about normal in size, and the wound has closed with the exception of a very small sinus about a half inch deep.

H. A. COTTELL, M. D., *Secretary.*

DEATHS OF EMINENT FOREIGN MEDICAL MEN.—The deaths of the following distinguished members of the medical profession abroad have been announced: Dr. Peter, Professor of Clinical Medicine in the Paris Faculty of Medicine; an obituary notice will be found in another column. Dr. J. Wojtaszek, *privat-docent* in Pharmacognosis and City Sanitary Officer in Cracow, of typhus fever contracted during the discharge of his duties. Dr. Modrzejewski, of Warsaw, who has written on deaf-mutism and a number of other special subjects of various kinds. Dr. Frederick A. Salzer, Professor of Surgery in the University of Utrecht. Dr. Delasiauve, formerly physician to the Saltpetriere, Paris.—*London Lancet.*

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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THE FIRST PAN-AMERICAN MEDICAL CONGRESS.

This great experiment in medical-society making was successfully tried on the 5th, 6th, 7th, and 8th inst., in Washington. The attendance was large and medically representative of the countries concerned. The Congress was opened by the President of the United States in a very brief but well-timed speech, and after a general session, devoted to reports and addresses, the society divided into twenty-one sections, whose work went on synchronously and successfully to the finish. The free interchange of ideas, opinions, and courtesies among physicians whose fields of labor are contiguous, and whose interests, at least in the epidemiological problems of the Americas, are common, is a triumph in medical reciprocity which does honor to the energetic projector of the Congress and his indefatigable committee of organization. In consequence of the absence of Spanish and Portuguese from the linguistic list of the average North American doctor, our brethren of Mexico, the Antilles, and the Southern continent have been more foreign to us than the doctors of Europe. That they have done and are doing sound work in the practice and advancement of medicine was fully attested in the able papers read and the lucid speeches made at the Congress by the delegates from the Latin Americas.

Time nor space will permit an analysis of the scientific work of the Congress, but a cursory perusal of the proceedings as published in the Eastern journals show that in quantity and quality it was equal to the

doings of similar large medical bodies. The social features were particularly interesting, and gave the visitors lavish proof of American (United States) hospitality.

The following, from the Washington correspondent of the *Journal of the American Medical Association*, shows that the medical press was well represented, and that its exponents took no inconspicuous part in the festivities of the occasion :

The American Medical Editors' Association met in Washington, in the large banquet hall of the Arlington Hotel, on Monday, September 4th. The President, Dr. C. H. Hughes, of the *Alienist and Neurologist*, read a short and pithy address of welcome to the invited guests, and the versatile Vice-President of the American Medical Association, Dr. I. N. Love, of the *Medical Mirror*, was toast-master of the evening. To the toast of the "President of the United States," the Hon. J. Sterling Morton, Secretary of Agriculture, responded in a most happy manner. "The Secular Press," was responded to by Hon. Frank Hatton, editor of the *Washington Post* ; "The American Medical Association," by President J. F. Hibberd ; "The Pan-American Medical Congress," by President Pepper ; "The Medical Press," by Dr. Hobart A. Hare, of Philadelphia ; "The Surgeon-General of the Army," by ex-Surgeon-General Hammond, General Sternberg being absent ; "The Surgeon-General of the Navy," by ex-Senator John B. Henderson, of Missouri, who gave an interesting account of the purposes and objects of the Pan-American Congress over which he presided last year ; "The Public Health," and "The Journal of the American Medical Association," by Dr. John B. Hamilton.

The volunteer speeches brought out by the skillful touch of the toast-master were many and excellent. Among the most notable of the after-dinner volunteer speeches were those of Dr. Ernest Hart, of the *British Medical Journal* ; Dr. Phillipot, of Jamaica ; Dr. Abram Owens, of Evansville, and Dr. Garcelon.

In the intervals between the speeches, Major Stofer, the well-known Washington correspondent, rendered some pleasant musical selections, and Mr. Seabrook, the actor, gave one of his characteristic recitations.

As the evening waned, it dawned upon some of the invited guests that American medical editors knew how to enjoy themselves and take a few hours of recreation, as well as any other class of Pan-American citizens.

The construction of the next Congress was put in charge of an international executive committee (made up of one member from each country), who have accepted an invitation to hold the next meeting in the City of Mexico. The year will probably be 1898, but the season has not yet been determined. The President-elect is Prof. Rafael La Vista, the gifted and learned President of the University of Mexico.

JEAN MARTIN CHARCOT.

Since the date of our last issue a great spirit has passed from the realm of things medical and mundane into the unknown. Jean Martin Charcot is dead. Since the day of John Hunter no such genius for original investigation has appeared in the ranks of medicine. Like Hunter, he lived to work out what was in him, and came to his "grave in a full age, like as a shock of corn cometh in in his season."

Like Hunter, he touched almost every thing in medicine, and threw light upon every thing he touched.

Were a star quenched on high,
For ages would its light,
Still traveling downward through the sky,
Gleam on our mortal sight.
So when a great man dies,
For years beyond our ken
The light he leaves behind him lies
Upon the paths of men.

GRAILY HEWITT.—The death of Dr. Graily Hewitt, Professor of Obstetric Medicine in University College, London, and obstetric physician to the hospital, puts to rest a man whose name is honored wherever Obstetrics and Gynecology are taught and practiced. He was perhaps the most eminent English teacher and writer in these departments of medicine. His works are in the library of every progressive physician.

CRUEL ANTI-VIVISECTIONISTS.—The aigrette in a lady's bonnet is the crowning beauty of an egret mother. The collector—and each nesting season fifty men are employed in this business—waits till she is on her nest, her little breast full of peace, and the young just hatched, so that the mother will not leave them easily, though alarmed. He ruthlessly seizes her, tears off her crowning plumes and her wings, and then throws her down, gasping, torn, and fluttering, to die beside her little ones, who, deprived of her fostering care, die also miserably. Lately, at a meeting of anti-vivisectionists, it was a curious instance of "the evil wrought through want of thought" that many of the ladies protesting against the cruelty of vivisection wore these very egret plumes in their bonnets.—*Cornhill Magazine.*

Notes and Queries.

CARBONATE OF GUAIACOL.—The value of guaiacol in the treatment of tuberculosis is now fully recognized. The drug, however, has many disadvantages, both as regards taste and smell, and more especially as to the disturbances of digestion which it is likely to cause. Carbonate of guaiacol has therefore been recommended as in a great measure free from these disadvantages. Carbonate of guaiacol is a fine crystalline powder, free from odor, tasteless, and insoluble in water, but slightly soluble in alcohol, ether, chloroform, and benzol. Therapeutically it possesses all the properties of guaiacol, but, as already said, none of its disadvantages. MM. Seifert and Koelescher, who have prescribed the drug to sixty patients suffering from various forms of tubercle, speak highly in its favor and prefer it to creosote for the following reasons: Carbonate of guaiacol is not so irritating to the mucous membrane of the digestive tract; the gastric juice of healthy people has no effect upon it, and it is therefore not decomposed until it enters the intestine, when carbonic-acid gas and guaiacol are set free. The stomachs of tuberculous subjects, however, according to MM. Seifert and Koelescher, contain large numbers of saprophytic organisms, and the drug is decomposed more rapidly, the free guaiacol preventing the further development of bacteria and so improving the digestive power of the stomach. The free guaiacol is absorbed rapidly, appearing in the urine within half an hour to an hour after its administration. As the carbonate is only slowly decomposed, a uniform distribution of guaiacol throughout the intestinal juices can be obtained. Dogs and cats can take doses of 75 grams without any dangerous symptoms. Patients can be given 6 grams within twenty-four hours without discomfort, taken in divided doses. MM. Seifert and Koelescher likewise state that the blood of tuberculous patients contains pathological ingredients which cause hectic, night sweats, etc. Guaiacol unites with these bodies and forms inoffensive compounds, with immediate relief of the symptoms.—*London Lancet.*

A HEAVY, DULL HEADACHE situated over the brow and accompanied by languor, chilliness, and a feeling of general discomfort, with distaste for food which sometimes approaches to nausea, can generally be completely removed by a two-grain dose of the iodide of potassium dissolved in half a wine-glass of water, and this quietly sipped, the whole quantity being taken in about ten minutes. In many cases the effect of these small doses has been simply wonderful. A person, who a quarter of an hour before was feeling most miserable and refused all food, wishing only for quietness, would now take a good meal and resume his wonted cheerfulness. The rapidity with which the iodide acts in these cases constitutes its great advantage.—*Alienist and Neurologist.*

Special Notices.

The preparations of "PEPSIN" made by Robinson-Pettet Co. are endorsed by many prominent physicians. We recommend a careful perusal of the advertisement of this well-known manufacturing house. (See page —.)

THE advertisement of SENNINE, "The New American Antiseptic," appears for the first time in this issue. A product of Phenol and Boracic Acid, the two best germicides known—in powder form (2 oz. tin boxes with inner top perforated convenient in applying) and readily soluble, five parts of SENNINE dissolved in 100 parts of water. Comparatively inexpensive—non-poisonous and free from disgusting odor—safe internally as well as externally, thus promising much in general medicine as well as in Surgery. We bespeak an early trial of SENNINE by our patrons. Free sample sent upon application to the Dios Chemical Co., St. Louis, Mo.

APERIENT PILL OF SUMBUL: AN EFFICIENT COMBINATION.—SUMBUL, or musk-root, is an excellent antispasmodic and nervous tonic. Its action resembles that of musk and valerian. In small doses it stimulates appetite and improves digestion. It allays irregular nervous action and is beneficial in depressed or excitable condition of the nervous system. Sumbul may be very advantageously employed in the treatment of hysteria, neurasthenia, neuralgia, functional irregularity of the heart, restlessness, the insomnia of chronic alcoholism, and of nervous dyspepsia. The extract is given in the dose of $\frac{1}{4}$ to 1 grain. It is essential that it be made from a pure specimen. As most of these disorders occur in neurotic individuals—especially women—with impaired nutrition, a morbidly sensitive organization, dyspeptic difficulties, and sluggish movement of the bowels. I have advantageously, in many instances, associated it with nervine and laxative remedies. The following combination which I have devised is now put up on a large scale by the well-known manufacturing pharmacists, Messrs. William R. Warner & Co. Each pill contains:

| | | |
|---|-----------------------------------|---------------------|
| R | Extract Sumbul, | gr. i; |
| | Asafetida, | gr. i; |
| | Extract cascar. sagrad, | gr. ss; |
| | Aloin, | gr. 1-10; |
| | Extract nucis vom., | gr. $\frac{1}{8}$; |
| | Glycerine, | gr. $\frac{1}{4}$. |

M. The dose is 1 or 2 pills.

From a long list of cases in which the above pill proved of value a few examples are selected:

A light-complexioned, florid young woman became subject to spasms of hysterical chorea. There were twitching and jerking of the muscles of the forearm and face. Two pills were administered thrice daily with excellent results. The paroxysms gradually became less frequent and at length ceased.

A woman was subject to aching pains in the loins, radiating to the pelvis and groin. Attacks of intercostal neuralgia also occurred; she was weak and often had palpitation of the heart. The patient made a complete recovery.

The same treatment was of marked benefit in the case of a woman who, consecutive to her first confinement, had suffered for nearly a year from palpitation, dyspepsia, constipation, mastodynia, headache, and giddiness. The action of the heart was rapid and irritable, but there was no organic disease.

A lady, about five weeks pregnant, suffered from an almost constant headache and could not sleep well; was nervous, depressed, weak, dyspeptic, and constipated. The pills corrected the state of the digestive apparatus, banished the pains and nervousness, and the patient progressed without special difficulty to the end of her term. *Abstract of a paper by John V. Shoemaker, A. M., M. D., in the Medical Bulletin for May, 1893.*

Foreign Correspondence.

LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

Manchester and Sewage Disposal; The Author of "Dr. Janet of Harley Street;" Blind Cyclists; More Cholera Experiments; An Ambulance Brigade under Canvas; A New Departure at a Public Dinner; The Poplar Hospital; New Legislation for Inebriates; The Public Health.

The Manchester corporation have for some time been making experiments in sewage purification which are now rapidly drawing to a close. Until a few years ago the authorities were satisfied with what is known as the lime process of treating and purifying the sewage. It is a process which is said to possess the merits of cheapness and simplicity. By general consent, however, it is inefficient. The effluent as it is discharged from the works looks pure enough, but after it is discharged it decomposes and gives off a bad smell. For four years the corporation have been engaged at their works making experiments with various methods of dealing with sewage. The processes which have been experimented with have numbered twenty in all, and the tests appear to have been carried through in a very exhaustive manner. The report is in favor of the adoption of the international process of precipitation and filtration, which is a combination of chemical and mechanical methods.

Dr. Arabella Kenealy, the author of "Dr. Janet of Harley Street," a novel which has reached a fourth edition, is said to have entered the medical profession with the express intention of bringing its resources to bear upon fiction. Having showed considerable literary talent at a very early age, the burying herself in medical student life for the lengthy period over which the attaining a degree extends was regarded by her acquaintances as a waste of time. But Miss Kenealy is convinced that the time could not have possibly been better spent; that for the study of human nature and a thorough realization of some of its most suggestive phases the life of a doctor is pre-eminently fitted.

A party of blind cyclists through a serious accident had to abandon a tour from London to the extreme north of Scotland. The party, which started from the grounds of Mr. Gladstone's official residence, had traveled as far as Barnet, when the neck of the tandem driven by Dr. Campbell (the founder of the Royal Normal College for the Blind) suddenly snapped, throwing the rider heavily to the ground. Upon being picked up he was found to have fractured his collar bone and some of his ribs. At the time of the accident

the cyclists were proceeding at the rate of between eight and ten miles an hour on a bad road.

Professor Emmerich, of Munich, assisted by Professor Tsubio, of Tokio, has been investigating Asiatic cholera with the result that after long experiments of the most delicate and minute description he is satisfied that Asiatic cholera is due to nitric poisoning produced by the bacilli discovered by Professor Koch. Extensive experiments have been made upon animals, and it has also been found by spectral analysis that those succumbing to poison by nitric acid furnish identical symptoms and characteristics with those who die of cholera.

For the fourth year in succession the St. John Ambulance Brigade have spent a week under canvas in one of the metropolitan suburbs. Members of the London, Northampton, and St. Albans districts mustered at the headquarters of the brigade. At St. John's-gate, Clerkenwell, and accompanied by a number of cyclists, nurses, and ambulance wagons, together with three bands, marched through London to the encampment, where twenty-six bell, two hospital, and three tortoise tents had been pitched, the accommodation being for two hundred men.

A large company met at the Hotel Metropole to celebrate by a public dinner the granting of a charter to the Royal British Nurses' Association. Sir William Savory presided, and was supported by Sir Dyce Duckworth, Sir Spencer Wells, Dr. and Mrs. Bedford Fenwick, and many other members of the medical profession. Specially honored was the health of Princess Christian, who has worked hard to help the nurses, and is president of the corporation. One of the features of the speeches was that for the first time in the annals of public dinners a lady, Miss Loch, Superintendent of Her Majesty's Indian Army Nursing Service, responded for the army.

Permission was kindly granted by the Lords of the Admiralty for a public inspection of Her Majesty's ship Theseus, for the benefit of the Poplar Hospital. The vessel had just been completed and was lying in the Victoria docks. Poplar Hospital is the only institution of its kind for accidents in London-over-the-border. Situated at the very gates of the East India docks, it is open day and night for the relief of the terrible accidents which daily occur in that neighborhood. During the past twelve months more than 13,800 accidents have been treated in the hospital. The Governors are now endeavoring to extend these benefits to women and children. For this purpose they desire to raise the sum of £5,000, and to this object all the proceeds from the inspection of one of the latest additions to Her Majesty's fleet were given. The charge made was from eleven till two, five shillings, and from two till six, two shillings and sixpence.

The Home Secretary is expected to embody in a bill, to be introduced next session, a series of recommendations by the Departmental Committee on the treatment of inebriates. The report of the evidence shows that twenty-four witnesses were examined, including Sir John Bridge, Chief Magistrate, Bow Street; Sir Andrew Clark; Dr. Hoffman, Inspector of Inebriates' Retreats,

the Governor of Pentonville Prison, and Sir Richard Quain. The notes of evidence show practical unanimity in favor of the recommendation of the committee with reference to cases of drunkenness, to which the Inebriates Acts were directed. Of these the more important were the encouragement of retreats for those who can not provide the whole of the funds necessary for their maintenance, the residue to be supplied by voluntary contributions, and if thought desirable by aid from the public rates; the extension to two years of the maximum period for which a patient may be confined in a retreat; the liability of the property of persons committed for their maintenance, and an appeal to a divisional court against an order. As to the habitual drunkards who come within the action of the criminal law, the committee recommend that additional powers should be given to magistrates to bind in sureties and recognizances for a considerable period habitual drunkards, that reformatory institutions should be provided, aided by contributions from imperial and local funds, and that magistrates should have the power to commit to such reformatory institutions for lengthened periods, with or without previous punishment of imprisonment, habitual drunkards who come within the action of the criminal law, who fail to find required sureties and recognizances, who are proved guilty of ill-treatment or neglect of their wives and families, or who have been convicted of drunkenness three or more times within the previous twelve months.

At the present time influenza has almost disappeared from the metropolis, the number of deaths attributable to that malady having fallen to three in seven days, the lowest figure recorded for a long time. Neither small-pox nor scarlet fever is increasing, but unfortunately diphtheria is. Speaking generally, the health of the metropolis is good, the death-rate having fallen from 22.5 to 21.

Mr. Arthur Durham, Senior Surgeon to Guy's Hospital, has lost a son, who died of pharyngeal diphtheria, contracted while carrying on his duties as assistant medical officer at the London Fever Hospital.

LONDON, August, 1893.

DO THOSE WHO ARE SERIOUSLY ILL EVER SNEEZE?—This is a point alluded to by Mr. Jonathan Hutchinson in the January number of his Archives. He does not recollect himself to have seen any but fairly healthy persons sneeze. He puts the question with especial reference to the widely spread popular superstition that sneezing is a sign of health and good luck. It is possible, he thinks, that this may have had its origin in the fact that it is for the most part an act restricted to those in fair health. Tylor, in his "Primitive Culture," gives interesting facts as to the prevalence of this creed and as to certain customs associated with it, and traces it in part to doctrines of animism, but Mr. Hutchinson thinks the suggestion he has given may also have some value.—*Sheffield Medical Journal*.

THE AMERICAN PRACTITIONER AND NEWS.

"NEC TENUI PENNÄ."

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SATURDAY, SEPTEMBER 23, 1893.

No. 6.

D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

A Journal of Medicine and Surgery, published every other Saturday. Price, \$3 per year, postage paid.

This journal is devoted solely to the advancement of medical science and the promotion of the interests of the whole profession. Essays, reports of cases, and correspondence upon subjects of professional interest are solicited. The editors are not responsible for the views of contributors.

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MYXEDEMA AND ITS TREATMENT.

At the eighth annual meeting of the Association of American Physicians, Washington, D. C., Dr. James A. Putnam, of Boston, read a paper upon this subject. The author reported two cases of myxedema successfully treated by thyroid preparations of different kinds. The first case was in the person of a middle-aged lady who had had the disease in a typical form for more than twelve years. In two weeks under treatment by hypodermic injection signs of improvement appeared. Though anemic and delicate, she is now practically well, and her scalp, which grew bald during the course of the disease, developed a dense growth of hair. The second case was also in the person of a lady in whom the disease appeared about the time of the menopause. In this case there was a family tendency to the disease. The thyroid gland had been enlarged for several years, and tachycardia was present. Improvement was rapid, all the symptoms except the goitre disappearing. The author discussed the relation of myxedema to acromegalia and to Graves' disease. There would seem to be not sufficient grounds for asserting any very close relationship between the affections, Graves' disease not being due to the enlargement of the thyroids in the same sense that myxedema is due to atrophy of that organ.

The results of partial thyroidectomy, which appear to have been so successful in relieving the symptoms of Graves' disease, form an argument of value in favor of the thyroïdal origin of that affection, but the question

can by no means be decided positively on that side. The evidence that Graves' disease is essentially a cachexia due to disordered tissue nutrition, in the same sense as with myxedema, is not strong, and the theory that the symptoms are due to excessive or vitiated thyroid secretion, though important, still lacks proof. The occasionally rapid onset of Graves' disease under excitement or nervous shock is not easily explained in that way, though not positive disproof of the theory. The truth probably is that Graves' disease is closely related to the cardiac-regulatory and vaso-motor functions of the thyroid, and very little to its trophic functions. It is difficult to define the condition of the thyroid necessary to produce myxedema, etc. Sometimes its functions seem to be only temporarily inhibited. It is probably not true, however, that a small part of the gland is functionally equivalent to the whole.

The recent observations respecting the pathological anatomy of the myxedematous condition were cited, and the conflicting evidence regarding the supposed compensatory enlargement of the hypophysis cerebri after thyroidectomy, and regarding the function of the hypophysis. There is perhaps an analogy between the cachexia thyreopriva and eunuchism after castration.

This report was followed by a paper upon the same subject by Dr. M. Allen Starr, of New York, who reported three cases of myxedema successfully treated by means of the glycerine extract of thyroid gland. The patients were all women, two aged forty-six, and one aged twenty-two. In the first case, under six drops of the extract three times a day, increased by one drop daily, improvement was noticeable in ten days, and has since been progressive and continuous. The edema has practically vanished. The patient is free from pain, sleeps well; her temperature has risen from ninety-seven to normal, she is able to walk several miles a day, and the improvement of her mind has been more marked than that of her body. The dose of the extract was increased to ten drops three times a day, at which point it produced a feeling of exhaustion. The pulse was found to be over one hundred and the temperature ninety-nine and five tenths. The dose was reduced to eight drops three times a day, and was held at that point for a month. This is equivalent to half a gland daily.

In the discussion that followed several cases were reported, notably three by Dr. F. C. Shattuck, in which the extract had been used with rapid abatement of symptoms and no untoward results except in one case (perhaps three) wherein the treatment had to be stopped on account of the very severe nocturnal paroxysms of pain, like angina, which supervened. This was accompanied by great pain just outside the left

nipple and inability to lie on the left side. The pulse would rise from seventy to one hundred and twenty as the pain came on. After three weeks' intermission, however, the treatment was resumed and continued without further trouble. This patient got dessicated thyroid extract, fifteen grains in capsules three times a day. Another patient, a female, developed severe pains in the legs upon the same treatment. She had been fairly subjected to the treatment without improvement.

The especial points to which Dr. Shattuck called attention were the failure of the treatment thus far in a case which seems undoubtedly one of myxedema, and the toxic symptoms noted more or less in all three, namely, pain in the legs, papitation, and severe angina. We are dealing with a powerful agent, and should be very careful until we are more familiar with its doses than we are at present. Among the many points which experience will enlighten us upon is the relation of the dosage to the duration or intensity of the disease. The descriptions of myxedema, as laid down in the books, apply to old and very marked cases. As we learn to recognize the early stages of the affection we shall find that cases are pretty common.

Dr. M. Allen Starr, of New York, called attention to the necessity of varying the dose of the drug somewhat in accordance with the reaction of the patient. Different individuals are apparently differently susceptible to the thyroid extract. In one of his cases, owing to a misunderstanding between physician and nurse, the dose was run up to twenty-two drops of the glycerine extract three times a day, which is equivalent to two and one fourth glands per day. This was not followed by any apparent ill effect. In Dr. Thompson's case no effect at all was seen until the dose was run up to eighteen drops of the extract three times a day. It is better to gradually increase the dose until pretty large doses are given. Recently, in the discussion in Edinburgh on myxedema, from out of a large number of cases reported (nearly seventy) there were but two cases of failure to relieve the patient by the use of thyroid extract.

It begins to look, in spite of the wrecks of the Brown-Sequard elixir, the tuberculin of Koch, etc., as if at last an organic extract had been found that is possessed of real therapeutic efficacy in the treatment of serious leisonal (secondary at least) disease; and if this be true, the practitioner, while in no haste to take up these apparent fads, may well suspend judgment till the dreams of the dreamers have been put to searching tests.

Notes and Queries.

THE BORDEN TRIAL.—The trial of Lizzie Borden which ended with the acquittal of the defendant, has engaged the attention of the whole country, by reason of the extraordinary brutality of the crime and the mystery connected with its perpetration. The details have been made familiar to every one. Some expert testimony was introduced, but this was mainly of a negative character, and did not involve any especially interesting points. The prosecution apparently tried to make out that a young woman of previously good character and quiet habits had hacked to death her father and stepmother. It is the general opinion, we think, that the chain of circumstantial evidence which was fastened about her was not strong enough to justify a conviction.

Miss Borden being removed from the list of possible criminals, the theory—where any theory is held—is that the deed was done by some cunning maniac. If so, it must have been a person who had an insane lust for murder, and who would be put in a similar class with “Jack the Ripper.” If there be such a person, he or she is living yet, and will most likely be heard from again. The acts of such criminals, however, are as a rule unlike those of the Borden case, for there is either some sexual or religious perversion, or, at least, some insane emotion connected with them. The theory of an unknown maniac is, therefore, not a very strong one. There is, in fact, no very strong theory, though that of the prosecution was at one time the most plausible.—*Medical Record.*

THE TRUE SWEETBREAD. regarded by gourmets as a great delicacy, is the thymus gland of the calf. As a rule, this is found only in the fetus and young calf, under the lower surface of the trachea, “partly without and partly within the chest, between the layers of the anterior mediastinum.” It is occasionally persistent, but usually disappears within a few months after birth. It is elongated, of a grayish-white color, irregular—that is, lobulated on its surface, and much more resembling a salivary gland and the pancreas than the thyroid. It is commonly known among butchers as the “throatbread,” and is rarely found except in animals supplying young veal or lamb. The pancreas is vulgarly termed the “gutbread” or “belly sweetbread,” and is the article which would be supplied in the great majority of cases by butchers asked for sweetbread. The thyroid is situated at the upper part of the neck, not at its root, and is not regarded as a favorite article of diet. Though the lobes are closer together than in man, they are spoken of as two, each being named a “kernel” or “gland.” As far as we can learn, they are not ordinarily included among the sweetbreads. As

compared with the thymus and pancreas the thyroid is very small, regular on the surface, ovoid in shape, reddish-brown in color, situated at the upper part and not at the root of the neck. The thyroid is sometimes confused by butchers with the lymphatic glands of the neck. Its dark color and characteristic shape—convex externally while somewhat concave and flattened where it rests against the trachea—should prevent this mistake. While thymus and pancreas are valued highly, the market value of the thyroid is inconsiderable, and until its association with myxedema it was rarely asked for.—*British Medical Journal*.

APPENDICITIS.—Our friends the surgeons, puffed up with their marvelous success, desiring new worlds to conquer, have attempted to wrest from the practitioner nearly every region of the body. They have attempted to classify all the affections about the cecum as appendicitis, claiming it as a surgical affection. The pendulum is swinging back, and a more conservative view will prevail. The majority of these cases can be managed by the practitioner, though in a proportion of cases surgical interference is absolutely necessary.

CRANIECTOMY.—Likewise the *furor* for craniectomy is subsiding. In a majority of instances the operation is irrational and ineffectual, the operator losing sight of the fact that disease of the brain, arresting its development, is the cause of thickening or other manifestations of want of development of the cranium. Removal of parts of the bony framework can have no possible good effect on brain massed, atrophied, or sclerosed by previous disease.

Special Notices.

What is to be done to stay the fearful curse, drunkenness, that has already fastened itself upon the nation, and is growing greater as time passes, is a question that is interesting many of the best minds of the present day.

Moral influence has been thoroughly tried and has done good when the taste for alcohol has not been acquired; but when the habit is formed, suasion and example are of little avail. To relieve the insatiable craving of the inebriate and restore him to a condition of health, medical treatment must be resorted to, and no remedy more fully meets the requirements in such cases than "ANTIDIPSOLE," which under no circumstances can possibly injure the patient. As an evidence of its growing popularity it is being used in every section of the country, and is doing good work.

T. H. J. PRICE, M. D., ETC., No. 4 Lorne Villas, Clevedon, Somerset, England, May 23, 1891, writes: I take pleasure in giving the following notes on BROMIDIA.—A patient, age twenty-eight, suffering from Pneumonia and Typhoid Blood Poisoning (the latter was contracted when in the convalescent stage), complained of Insomnia, and I put him on BROMIDIA. Even when in good health he had suffered more or less from Insomnia, but after having taken BROMIDIA he slept without difficulty and very naturally, and no headache or constipation followed its use, as was the case when other narcotics were administered. I was very pleased with the results, and prescribe BROMIDIA often now.

THE AMERICAN PRACTITIONER AND NEWS

"*NEC TENUI PENNĀ.*"

VOL. XVI.

LOUISVILLE, KY., OCTOBER 7, 1893.

NO. 7.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

THE PRESENT STATUS OF PASTEUR'S ANTI-RABIC INOCULATION.

BY J. S. LEONHARDT, M. D.

An interesting editorial in the American Practitioner and News of the issue of July 15, 1893, opens as follows:

At a recent *fête* organized for the express purpose of honoring the illustrious savant (Pasteur), no less a personage than Sir Joseph Lister, who was one of the principal orators, felt constrained to declare that if M. Pasteur had been prematurely credited with having found a definite cure for hydrophobia, the fault lay with his eager admirers, and not with himself. This is a virtual surrender of the entire question.

A candid review of the brief though brilliant history of inoculation against hydrophobia does not, in my opinion, warrant the language used by the eminent Englishman on that occasion, nor justify the able editors of the Practitioner and News in forthwith inditing an obituary on the discovery and practice of anti-rabic inoculation.

Pasteur's first inoculation practiced on the human subject was done July 6, 1885. The patient was Josef Meister, an Alsatian child nine years old. He had been bitten by a rabid dog about three weeks before. He was wounded in fourteen different places on the buttocks, legs, and hands; symptoms of the dread disease had already manifested themselves when Pasteur was consulted. The boy was subjected to the "intensive" method, recovered, and, so far as I am able to learn, has remained in good health ever since.

October 26, 1885, M. Pasteur first submitted his work for approval before the Academie des Sciences. By March 6, 1886, 350 persons had been treated for the prevention of hydrophobia. The London Lancet, commenting editorially upon the record, remarks that since more than sixty days (the usual incubatory period in the human bitten by a mad-dog) had elapsed since the majority of this number had been inoculated and no symptoms of the disease having developed, much was to be expected of the new method. He says, further, that a few more months of this kind of work, maintaining such good results, would prove the method a "boon to humanity, a gain to science, and justly merit the applause of the human race." By April 12, 1886, 726 had been treated, and by the following May 4th the list had increased to 950, and the "good results" were constantly maintained.

In June, 1886, the Academy of Science, Paris, appointed MM. Chantemesse and Charin a committee to analyze the record of 1,335 persons that had been treated by the new method up to that time. In order to eliminate all doubtful or ambiguous elements in their report they divided the total number of cases into three classes:

1. Those who had been bitten by dogs positively rabid, having communicated the disease to other animals.
2. Those bitten by dogs pronounced mad during life or after death by veterinarians.
3. Those bitten by dogs of which nothing was known.

Of 96 patients belonging to the first class, one died, a death-rate of 1.04 per cent. Of 644 persons of the second class, three died, a mortality rate of 0.46 per cent. Of the remainder, belonging to the third class, none died. These results, compared with the statistics of M. Leblanc on "Hydrophobia in the Department of the Seine," showed that the statistical death-rate of 160 per thousand had been lowered by the new method to 7.5 per thousand, and the mortality from rabid wolf bites from 820 to 140 per thousand. The committee continuing their work along this line established some special statistics respecting the fatality of bites when inflicted in the face, on the hands, or other uncovered parts of the body. Among 54 persons bitten in the face and on the hands by dogs known to have been mad experimentally, there was one death, a rate of 18 per thousand; of 400 cases in which persons had been bitten in the face or on the hands by dogs known to have been mad clinically, three died, a rate of 7.5 per thousand. A reference to the documentary statistics of the Council of Hygiene from 1862

to 1872 showed a mortality rate of 880 per thousand in persons bitten in the face, and 672 per thousand in those bitten on the hands. In July, 1886, M. Grancher, M. Pasteur's medical assistant, made use of the above statistics and facts in a lecture delivered before a magnificent audience gathered at the Paris Exhibition of Hygiene. In an incredibly short period of time the ardor and enthusiasm of that liberal people made it possible to raise a million dollars for the purpose of further prosecuting these humane investigations.

In a personal communication to Dr. Davis, of Philadelphia, M. Pasteur gave a *resumé* of his experience with anti-rabic inoculation from the beginning of his work to September 1, 1886, as follows (Science for October 22, 1886):

| COUNTRIES SENDING PATIENTS. | TREATED. | DIED. | REMARKS. |
|-------------------------------|----------|-------|--|
| France and Algeria, | 1,324 | 4 | Too late for treatment. |
| England, | 68 | 1 | |
| Austria-Hungary, | 43 | 0 | |
| Germany, | 9 | 0 | Average failure is one for every 150 foreign persons treated, and one for every 350 French and Algerian. |
| United States, | 18 | 0 | |
| Brazil, | 2 | 0 | |
| Belgium, | 50 | 0 | |
| Spain, | 75 | 2 | |
| Greece, | 10 | 0 | |
| Portugal, | 24 | 0 | |
| Holland, | 14 | 1 | Eight bitten by wolves, and four by dogs. |
| Italy, | 138 | 0 | |
| Russia, | 186 | 12 | |
| Roumania, | 20 | 2 | |
| Switzerland, | 2 | 0 | Six too late for treatment. |
| Turkey, | 2 | 0 | |
| Bombay, | 1 | 0 | |
| Total, | 1,986 | 22 | |

In November, 1886, Pasteur reported to the Academie des Sciences the results of the employment of his anti-rabic inoculation during the year that had intervened since his first communication to that body, October 26, 1885. There had been treated in this time 2,490 persons, ten of whom had died. For five years preceding November, 1885, the annual death-rate from hydrophobia in the hospitals of Paris was twelve. During the year ending November, 1885, only three had died from rabies in the hospitals, and of these two had not been inoculated.

In the spring of 1887 the famous English Commission, consisting of Sir James Paget, Sir Joseph Lister, Sir Henry Roscoe, M.P., Dr. Richard Quain, Dr. Lauder Brunton, Professor Burdon Sanderson, Dr. George Fleming, Vet. Surgeon to the British Army, and Mr. Victor Horsley,

Professor Superintendent of the Brown Institution, were appointed by the British Government to investigate the methods and claims of the French biologist. Their report, submitted before the House of Commons, June 27, 1887, contained among much other matter, the following: "Of 233 persons bitten by animals in which rabies was proved, only four died; without inoculation at least forty would have died. Among 186 persons bitten on the head or face by animals in which rabies was proved, only nine died, instead of at least forty. Of forty-eight persons bitten by rabid wolves, only nine died, instead of at least thirty. It may hence be deemed certain that M. Pasteur has discovered a method of protection from rabies comparable with that which vaccination affords against smallpox. It would be difficult to overestimate the importance of the discovery."

Pasteur's inoculation against hydrophobia compares very favorably with results obtained in the other prophylactic inoculations. Before vaccination was in vogue the death-rate from variola was 500 per thousand; it has now dropped to 23 per thousand. Before veterinarians inoculated against charbon the per cent of deaths equaled 120 per thousand; it is now 5 per thousand. Dr. Domingo Freire, of Rio Janeiro, inoculated 1,109 of all nations and ages against yellow fever, using an attenuated culture of the micrococcus found in this disease, and none of them died. The Emperor of Brazil, in order to test the efficacy of this method of prevention, had 600 laborers working in a highly infectious locality inoculated, with the result that less than 1 per cent took the disease, while formerly 33 per cent died from it. While the yellow fever was raging at Vera Cruz, Mexico, Dr. Cramona inoculated the whole garrison, and the result was eminently satisfactory. Dr. Shakespeare, investigating Asiatic cholera in Spain, in 1885, after a very thorough and painstaking research and analysis, found that Dr. Ferran's anti-choleraic inoculations were very effective. In the towns and cities of the province of Valencia nearly 77 per thousand of the non-inoculated were attacked with cholera, of which 33.58 per thousand died; of those who had submitted to Ferran's method of prophylaxis but 12.69 per thousand were attacked, of which 3.41 per thousand died. The immunity from attacks was thus shown to be 6.06 greater in those that had been inoculated, and their immunity from death 9.84 greater.

In commenting on the report of the English commission mentioned above the erudite editor of the London Lancet, observes: "Their verdict is the most important yet pronounced upon the subject, and must

go far to decide the question of the prophylactic value of the inoculations of Pasteur. The conclusion that the method has saved a considerable number of lives, and that it is at present, and probably will be for a long time, the only mode of saving from death those who have been bitten by rabid dogs, affords strong support to Pasteur's conclusions, and, we need hardly say, must have important practical results."

Dr. A. N. Blodgett, of Boston, has said that "the general opinion is that inoculation in the way advocated by Pasteur is not only an absolute protection to the patient against the outbreak of the rabid disease, but that it is itself entirely free from serious effects upon the inoculated person." While this is doubtless true in almost all cases, the "intensive" method has made a few exceptions to the rule. Dr. D. T. Himes, of London, has expressed himself in the following glowing and beautiful language: "The success of Pasteur's treatment has been brilliantly demonstrated by statistics as well as by experiments. Pasteur has established a prophylactic treatment against rabies, one of the most formidable and hitherto intractable of diseases. He has thus crowned a glorious career of research directed to the benefit of man by a most notable discovery primarily salutary to man himself."

The Academy of Medicine at Rome has adopted his conclusions, the German Government has done the same through Koch and Virchow. The Bacteriological Laboratory of Harvard University has also confirmed the findings of the great French savant. Among individual names that ascribe incalculable value to Pasteur's discovery may be mentioned Professors Huxley, Lankester, Erichsen, and Marshall; Sir Andrew Clark, Sir John Lubbock, Sir John Stokes, Sir William Bowman, Ernest Hart, and a multitude of others equally learned might be added.

In further confirmation of the genuine greatness and inestimable value of this latest gift to the race, let the following tabulated statement, taken from Vol. 1, No. 3, of the Therapeutic Review, bear witness:

STATISTICS OF THE ANTI-RABIC INOCULATIONS MADE AT THE PASTEUR INSTITUTE IN PARIS FROM ITS FOUNDATION IN 1886 TO 1892 INCLUSIVE.

| YEARS. | PERSONS TREATED. | DIED. | PER CENT OF DEATH-RATE. |
|------------------|------------------|-------|-------------------------|
| 1886, | 2,671 | 25 | 0.94 |
| 1887, | 1,770 | 14 | 0.79 |
| 1888, | 1,622 | 9 | 0.55 |
| 1889, | 1,830 | 7 | 0.38 |
| 1890, | 1,540 | 5 | 0.32 |
| 1891, | 1,559 | 4 | 0.25 |
| 1892, | 1,790 | 4 | 0.22 |
| Total, | 12,782 | 68 | 0.52 |

Will the reader kindly notice that for each successive year the death-rate shows a marked decrease. The progressive improvement of Pasteur's method of preventive treatment against hydrophobia is very plainly indicated in the work done at the New York Pasteur Institute during the year 1892, under the management of Dr. Paul Gibier. A total of 104 persons were treated at this institution during the past year. According to the classification adopted by MM. Chantemesse and Charin, 47 came under the first class, 42 under the second, and 15 under the third. In cases of the first class 5 were bitten on the head and face, 30 on the hands alone, 7 on the limbs and body, and 5 elsewhere. In cases of the second class 2 were bitten on the head and face, 32 on the hands, and 8 on the limbs and body. In cases of the third class 1 was bitten on the head and face, 8 on the hands, and 6 on the limbs and body. Among these cases occurred 39 simple and 39 multiple bites on the head, face, and hands. No death has been reported among these persons up to the present month.

LINCOLN, NEB.

MICROBES: A REVIEW.

BY JAMES WEIR, JR., M. D.

At the present time the study of the various microbes harmful to the human race is of surpassing interest. Europe has only recently emerged from an endemic of cholera, and the daily press has been full of numerous descriptions of this dread disease, its fearful ravages, and its deadly microbe. Yellow fever has unfurled its saffron banner in some of the southern continents, and in the North smallpox is beginning to leave the imprint of its sign manual on the faces of those unfortunates who come in contact with its specific bacillus. In the short space of an article like this it will be impossible to embrace the whole field of micro-biology, therefore I will simply endeavor to give a lucid plan of classification and a description of the most prominent microscopic organisms which are now held to be the factors in diseases of various types both in man and beast. This plan of classification and description is a modification of Troussart's, whose excellent work has been of material assistance to me in the preparation of this review. I differ very materially with him in some of his deductions and con-

clusions, but this paper is not controversial, therefore I will not introduce these points of difference. It has not been fully determined to which family *microbes* belong. Some microscopists consider them to be plants (*microphyta*), while others consider them to be animals (*microzoaria*).

In 1878 a French scientist, Sidillot, coined the term *microbe* (*micro*, small, and *bios*, life), and as this name describes them without specifying their particular kingdom I will use it. Haeckel believes that they are a kingdom of their own, intermediate between the animal and vegetable kingdom. He has proposed the name Protista, a word the sense of which is almost the same as that of the word microbe. In the *monera*, *infusoria*, *algæ*, and in other low forms of life it is almost impossible to classify some individuals and place them either in the vegetable kingdom or in the animal kingdom. This difficulty, as far as outward appearances go, exists in some of the higher forms of life, viz., the sponges and sea anemones—true animals simulating plants—and the insectivorous plants and so-called sensitive plants—true plants simulating animals.

The part played by microbes in nature is a most important one. We find them everywhere. Troussart says: "These microscopic fungi have their use in the general economy of nature; they are nourished at the expense of organic substances when in a state of putrefaction, and reduce their complex constituents into those which are simpler—into soluble mineral substances which return to the soil from which the plants are derived—and so serve afresh for the nourishment of similar plants. They clear the surface of the earth from dead bodies and fecal matter, from all the dead and useless substances which are the refuse of life, and thus unite animals and plants in an endless chain. All our fermented liquors are produced by the species of microbes called ferments, and from this point of view are profitable and beneficial. There are, however, thousands of microbes injurious to us. Such microbes are those which produce disease in alimentary and industrial substances, and also those which produce disease in the human race and in domestic animals."

The germs of these diseases are the spores of these microbes, and float in the air we breathe and in the water we drink. The first microbe I shall attempt to describe is a fungus and belongs to the family *Ascomycetes*. The fungi in this group possess endogenous spores each inclosed in a sac which is called an *ascus*, hence the name, *Ascomycetes*. The technical name for the fungus is *Claviceps purpurea* or the ergot

of rye. The fungus first makes its appearance on the flowers of the rye in a white mass called *sphacelium*. The mycelium, or body mass formed by the germination of the *sphacelium*, affects the grain and forms in it a thick felt-work, and is developed so as to form an elongated substance termed *sclerotis* (hard), or ergot. "This ergot remains quiescent during autumn and winter, but in the spring, owing to heat and moisture, the hyphæ or branches of the *sclerotis* swell and send forth numerous branchlets bearing at their extremities rounded heads in which the *asci* or sacs containing the endogenous spores are developed. These spores, issuing from these sacs, germinate on the blossom, producing a fresh *sphacelium*, then a second ergot, thus always passing through the same alternation of generation" (T.). Others of the *graminaceæ* produce ergots, and the ergot of wheat is said to be even better for medicinal purposes than the ergot of rye. I have artificially produced the ergot of wheat on buckwheat and rye. The microbe of ergot is a poison to both man and beast. In Southern France, Spain, and Italy the peasantry contract a very loathsome disease called *pelade* or *pelagra* from eating bread made of grain affected by this *ascomycete*.

There are certain parasitic fungi termed *tinea*, which attack the skin and mucous membrane of man and animals. These diseases are very contagious, inasmuch as the spores of the fungi are easily disseminated. The fungus which produces favus is called *Achorion Schoenleinii*. Under the microscope the mycelium shows elongated, cylindrical articulations which find their way among the cells of the epidermis, and sometimes penetrate deeply into the dermis. (My observations were made on a section of skin taken from the neck and stained brown with a weak solution of iodine.) Some of the shorter filaments terminate in chaplets of spores which are detached successively from the stem. *Trycophyton tonsurans* is another parasitic fungus, and attacks skin covered with hair. The mycelium of *Trycophyton tonsurans* has two sorts of hyphæ or branchlets, some simply nutritive, others with short articulations, separating into chaplets or crowns of rounded spores, which are continually detached (T.).

The mycelium frequently penetrates the epidermic cells at the base of the hairs. Sycosis is the same parasite as *trycophyton* in my opinion; the microscope shows little or no difference. *Trycophyton* may be transmitted to cats and dogs, and one source of contagion is undoubtedly our domestic pets. Another parasite transmitted by animals is *Tinea favus*. I once had a mouse whose head was one mass of *favus*. This

fungus caused necrosis of the cranial bones, and eventually killed its host. The spores and sphaecelia of *favus* are pigmented yellow, and give out an odor that is strikingly like that of the urine of mice.

Returning, a moment, to *Tricophyton tonsurans*, experiments in cultures show that this fungus can not be developed when the hair is entirely submerged in carrot juice, milk, or any liquid medium. Taking advantage of this fact, I have frequently exterminated the parasite by causing a serous effusion through the agency of carbolic acid and other vesicants. *Pityriasis versicolor*, so called from its varying color, is caused by the fungus *Microsporon furfur*. This fungus grows between the cells of the epidermis, and occasions their rapid destruction. The hyphæ are long jointed. The spores are not arranged in chaplets, but are found beneath the epidermis. The spores and sphaecelium are pigmented. I have had a field of *Microsporon furfur* on my own chest, developed from artificial cultures. This fungus is easily destroyed, mercuric chloride causing immediate death and dissolution of both spores and sphaecelium. The fungus of thrush, *Oidium albicans*, flourishes best in a slightly acid medium or pabulum; thus, it is generally found on the mucous membrane of the mouths of infants, invalids, and old people. This fungus has no mycelium, but is made up of hyphæ and spores (T.). My cultivations of this fungus always showed, when fresh, slight pigmentation. The color was light pearl-gray. This parasite perishes as soon as its habitat is rendered alkaline by Vichy water, bicarbonate of soda, borax, etc. Sulphur and its compounds are the germicides indicated in most of the diseases produced by *fungi*. Where sulphur fails mercuric chloride will generally prove effectual.

I will now discuss as briefly as possible some of the microbes found in the blood in febrile diseases, etc. The following classification, and I will ask your careful attention to it, is a modification of Wunsch's classification. I think it lucid and easily understood: Spherical or elliptic cells, colorless and generally motionless, are called *micrococcus*; cells elongated in short, movable rods are called *bacterium*; cells united in families, like frog spawn, are called *ascoccus*; unramified slender, filaments are called *bacillus*; long filaments are called *leptothrix*; filaments repeatedly bifurcated are called *cladothrix*; spiral, short, movable filaments are called *spirochæte*; spiral, long, flexible filaments are called *vibrio*; spiral, short, rigid filaments are called *spirillum*; filaments rolled into mucilaginous mass are called *myconostoc*; cells divided cross-wise, like packets tied with string, are called *sarcina* (T.).

I believe that the genus *micrococcus* is a mistake, and all of the so-called *micrococci* are nothing but the spores of organisms; I know this to be the case in *gonococcus*. Cultivations of *gonococcus*, in my hands, always produce a true *bacillus*. The most malignant of the *bacilli* is *Bacillus anthracis*, the exciting cause or *materies morbi* of the so-called splenic fever, which attacks most of our horned animals, especially cattle and sheep. Davaine first discovered the bacillus as early as 1850. Pasteur, in 1863, inoculated healthy animals with the infected blood, and thus found out that a very minute quantity was sufficient to produce a fatal attack of the disease. "In order to prove that the disease was really caused by *Bacillus anthracis*," says Troustart, "Pasteur inserted a very small drop of blood, taken from an animal which had recently died of anthrax, in a glass flask which contained an infusion of yeast neutralized by potassium and previously sterilized. In twenty-four hours the liquid, which had been clear, was seen to be full of very light flakes, produced by masses of bacilli, readily discernible under the microscope. A drop from the first flask produced the same effect in a second, and from that to a third, and so on. By this means the organism was completely freed from all which was foreign to it in the original blood, since it is calculated that after from eight to ten of such processes the drop of blood was diluted in a volume of liquid greater than the volume of the earth. Yet the tenth, twentieth, and even the fiftieth infusion would, when a drop was inserted under the skin of a sheep, procure its death by splenic fever, with the same symptoms as those produced by the original drop of blood. The bacillus is therefore the sole cause of the disease."

These germs are taken up by cattle and sheep while feeding, and probably pass into the circulation through some abrasion of the mucous membrane. Malignant pustule, which is simply splenic fever, affects butchers, tanners, and others who handle the flesh and hides of animals dead of this disease.

The prevention of anthrax is now secured through vaccination with the attenuated virus of anthrax. I will state, *par parenthese*, that if you examine the blood of an animal dead of anthrax twenty-four hours after death you will find that the *Bacillus anthracis* has disappeared and that a *vibrio* has made its appearance. This vibrio is an anaërobic and is sinuous, curled, and mobile. The *Bacillus anthracis*, on the contrary, is aërobic, straight, and immobile. This is the *Vibrio septicus* of Koch. The virus of rabies contains a bacillus short, straight, and immovable.

In 1884 Pasteur found means of attenuating this virus, and successfully inoculated himself and assistants. For this he was decorated. The microbe of glanders is a bacillus, and has been found in the lung, spleen, nostrils, and liver. Cultures can easily be made in neutralized solutions of extract of meat. By means of successive cultures, protected from atmospheric germs, unmixed bacilli can be procured. Animals inoculated with this pure culture die with glanderous tubercles in the lymphatic glands and other organs, thus proving that the bacillus is the cause of the disease. Certain microbes are always to be found in the human mouth. They are for the most part harmless, though in some mouths they become at times virulent intoxicants. Sternberg says that his own saliva possessed at times this peculiar property (T.). I should not be greatly surprised to find that the myth of the "blue-gummed" negro had its origin in this now clearly-established vagary of the buccal microbes and their specific ptomaines.

The microbes most frequently found in the mouth are *Spirochæte buccalis*, *S. plicatilis*, *Vibrio rugula*, *Bacterium subtilis*, and *Leptothrix buccalis*. The last mentioned microbe is large in size and very abundant. It is never absent from the tongue or interstices of the teeth, no matter how cleanly a person may be. Dental caries are occasioned by a microbe. It is a true bacterium when fully developed, though, owing to its polymorphism, it is frequently found as a micrococcus (T.). It has been recently ascertained with definite certainty that the different types of intermittent fever, tertian, quartan, etc., are produced by different microbes, and moreover that these microbes vary with the locality. Our intermittent fever is not the same as that of the Pontine marshes in Italy or the deadly jungle fever of the African coast. To an American belongs the honor of having first discovered that ague was due to a microbe. In 1869 Dr. Salisbury, of Cleveland, discovered and described a microscopic organism in the blood of people suffering with malaria. He described this microbe as belonging to the *Alga*, genus *palmilla*. The spores of this alga are always found in the saliva of persons who are the subjects of intermittent fever. It is easy enough to collect like spores by exposing glass plates at night in a malarious atmosphere. Earth taken from marshes is found to be full of this organism. When a marsh begins to dry up the spores of this alga are produced in countless millions and are disseminated throughout the atmosphere by currents of air, fogs, etc. "Salisbury has ascertained that there is a certain con-

nection between fogs and intermittent fevers, and this explains why people are more apt to contract fever in the morning and evening, at which times there is, in summer, always a fog floating to a varying height above marshy places" (T.). *Palmylla fibrilis* is polymorphic, and this fact explains the manner in which an aquatic alga can live in the human blood in the form of bacillus or spirillum. The site preferred by the malaria bacillus is the marrow of the bones and the spleen. In speaking of the peculiar phenomena of malaria, Troussart says: "The fact that the bacillus and its spores are successively found in the blood explains the intermittent type of the disease, tertian, quartan, etc., according to the variety of the marsh fever. According to its variety, and perhaps to the species of *schizophyllum*, the complete evolution of the plant sometimes demands forty-eight, sometimes seventy-two hours, and the access of fever always corresponds with the period of greatest activity in the bacillus, that which precedes the emission of spores. The different forms taken by *malaria bacillus* are only successive phases of its development."

At a certain period in its evolution the microbe attaches itself to a red corpuscle. The corpuscle by degrees loses its coloring matter and turns pale. It eventually disappears, leaving in its place a small grain of pigment. This pigment is the hemoglobin absorbed by the parasite. Soon two or three mobile filaments grow from the encysted microbe, which resemble vibrios, and as soon as detached move rapidly in the blood (T.).

Richard, in speaking of the spherical bodies or encysted form of the *bacillus malaria*, says: "The multiplication of these bodies must be extremely rapid; for instance, in tertian fever they are not found in the intervals of the attacks (*apyrexia*). As the attack approaches they appear in increasing numbers, and their maximum corresponds with the beginning of the rise of temperature; from that moment they begin to perish, since the heat of fever is fatal to them, and completely checks their development. This explains the intermittent character of the disease. They produce fever, the fever kills them, and then subsides; when *apyrexia* occurs they multiply again, excite fever, and so on." Unless its development is arrested by quinine the parasite continues to produce a series of auto-infections. The parasites or microbes of typhoid or typhus, on the contrary, are not affected by high temperature, as high even as 110° or 120°, or even higher; hence the continuous character of these fevers.

The jungle fever of India has been clearly proven to be occasioned by a microbe. Virchow and Obermeier discovered this fact as early as 1868. The microbe is called *Spirochæte Obermeieri*. It is a filamentous organism characterized by several spiral twists and very lively movements (T.).

The *micrococci* of yellow fever have been discovered and described by Freire, of Rio de Janeiro, and Cornil, of Paris. The parasites undoubtedly have their seat in the alimentary canal. The microbe producing typhoid fever is chiefly found in the mucous membrane of the intestines, in Peyer's glands, and in the round, red spots so frequently observed on the skin of typhoid fever patients. Recklinghausen first discovered and described the typhoid bacillus in 1871. I will state here that most of the microbes mentioned in this article are colorless and have to be stained before they can be observed. Ehrlich's method of staining with methyl violet will answer in most cases. I prefer, however, double staining, where possible, with *hemotoxylin* and *cosin*, especially in pathological specimens. The typhoid microbe appears in the form of short rods with rounded extremities. Cornil says: "From the position of the bacilli in a section of the mucous membrane it may be seen that they penetrate through its surface." I have never been fortunate enough to witness this myself, but he is a careful observer and I do not doubt but that he is correct. Their presence occasions an ulceration and sphacelation of the gut and consequent hemorrhage. An examination of the blood will show bacilli in prodigious numbers. Troussart says: "Many other bacteria appear in the intestines when the disease is approaching its end, but the characteristic bacillus of typhoid is the only one found in the blood and internal organs." This bacillus is easily cultivated on gelatine or potatoes.

In 1883 Koch was sent to Alexandria as a member of the German Sanitary Commission. He then and there discovered the microbe of cholera. He named it *Bacillus komma* on account of its form. This bacillus can be easily seen if the following directions are observed: A small quantity of the rice-water evacuation of cholera (that is, if you have a cholera subject, otherwise you can use cultivations) is placed on a glass slide, this is then stained with methyl violet, and the preparation examined under a magnifying power of 1,500 diameters, using an immersion lens and an achromatic light condenser. In spite of the coloring matter which they have absorbed the microbes may be seen full of motion and activity, which they retain for some time (T.).

Cultures of this microbe can be easily made in gelatine, milk, broth, eggs, moistened bread, potatoes, etc. The temperature most favorable to it is between 65° and 75° . Below 45° it grows very slowly. Cold does not kill it. It will resume its activity after being subjected to a temperature of 50° below freezing point, if brought into a higher temperature with favorable surroundings. This microbe is easily carried from place to place on the clothing, etc. It is aërobie, and soon dies when deprived of air. It starves in pure water. Water must be contaminated with refuse to produce a multiplication of the germs. Cornil says: "Bacilli cultivated in distilled water die within twelve hours, while they can live a week in drinking-water." The sun and air soon attenuate and destroy the microbes of cholera. Duclaux says: "In order to retain their virulence unimpaired, the microbes must travel in packages of clothing, in bales of rags, or in the close, moist holds of vessels. In a word, of all the agents of sanitation, the sun is at once the most universal, the most economical, and the most active to which the guardians of public and private hygiene can have recourse."

The microbe of cholera can not live in an acid medium, therefore, as a preventive acidulated drinks are recommended during an epidemic of cholera. Sulphur is fatal to the development of the microbe, therefore calcium sulphate is highly recommended. Oil of mustard, thymol, salicylic acid, and carbolic acid also retard and prevent its growth (T.). It will be impossible for me to describe in detail the other microbes which occasion disease. I will therefore mention only the name of discoverer, and date of discovery, and character of microbes most frequently met with: Measles, bacillus, Babés, 1880; scarlatina, micrococcus, Pohl, 1882; smallpox, micrococcus, Pasteur, 1873; croup, micrococcus, Forwad, 1881; diphtheria, microsporon, Klebs, 1873; phthisis, bacillus, Troussart, 1870; leprosy, bacillus, Hausen, 1880; pneumonia, micrococcus, Friedlander, 1882; warts, bacterium, Crudeli, 1882; balanitis, bacterium, J. Weir, jr., 1891.

There are also the microbes of erysipelas, of pus, of whitlow and agnail, of boil and carbuncle, and of phlegmon, of pyemia and septiemia. I can not prolong this paper by a description of how microbes produce disease by the production of certain toxic media, termed ptomaines.

URETHRAL GROWTHS: WITH A CASE.*

BY THOMAS S. BULLOCK, M. D.

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The urethra of the female is more prone than that of the male to be affected with new growths. They are divided according to their structure. The most frequent are what are denominated carunculæ and polypi. The carunculæ almost without exception grow from the mucous membrane of the urethra, and are invariably excessively sensitive. The patient complains of intense pain on micturition, sexual intercourse, in walking, and upon the slightest contact with the clothing. Pain is increased by the warmth of the bed, and the patient becomes extremely nervous and hysterical. Rarely, however, does serious mental trouble ensue, though one or two cases of suicide are recorded. Polypi in this situation vary in size from that of a pea to a hazel-nut. They are usually pedunculated, and bleed readily and are very sensitive. Their most frequent seat is the external orifice on the posterior wall, a short distance from the entrance.

Carcinomatous neoplasms are extremely rare, and are usually the result of extension from the vulva or vagina. *Venous angioma* affects the urethro-vaginal tubercle or the anterior half of the urethro-vaginal septum. Not infrequently it attains a large size and projects between the labia; it is not at all sensitive; sarcoma, only one case reported. *Prolapse of the urethral mucous membrane* or *eversio urethræ* is not common. In addition to the prolapse of the mucous membrane there is a proliferation of the connective tissue. It is met with both in the young before the age of puberty, and also in old multiparæ. In the latter it is thought by Dr. Emmet to be due to pressure during labor, by which the tissues are forced into the urethra from behind, causing dilatation of the canal, either partial or extending to the outlet. At the same time there is a laceration of the submucous tissues. The tissues at the neck of the bladder are free, and by pressure of the child's head are crowded into the urethra in the same manner as the rectal tissue is rolled out of the anus. This condition may exist for a long time without symptoms, but, as a rule, after a time it develops extreme sensitiveness, and soon creates difficult and painful micturition, pruritus vulvæ, and leucorrhea.

*Read before the Louisville Medico-Chirurgical Society, July 21, 1893. For discussion see p. 269.

Fibromata also occur. They are painless, have a smooth surface, and are elastic. As to the diagnosis of urethral neoplasms. Carunculæ can only be confounded with two conditions; one is prolapse of the urethra and the other syphilitic, warty growths. From the first it is distinguished by careful examination, which will reveal the fact that it completely encircles the meatus; from the second by the presence of other evidences of syphilis around the vulva and on other portions of the body. Urethral venous angioma is recognized by its color and lack of sensitiveness, fibromata by their smooth surface, elasticity, painlessness, and the fact that they do not readily bleed on manipulation.

Many of these growths may exist without causing trouble. This is the case with small condylomata, fibromata, and mucoid polypi. If they attain any size, the first symptom is a disturbance in the excretion of the urine; later, pain on micturition, pruritus, frequent desire to void the urine, and dysuria. As the growths enlarge, the urethra is dilated, the mucous membrane becomes hyperæsthetic and hyperemic, and a catarrhal inflammation is set up. Following this are erosions and fissures.

Treatment. If the growth causes no trouble, non-interference is the rule, but if it causes pain or disturbance of function it should be removed. This is best accomplished by excision, followed by thorough cauterization with nitric acid, or, better still, the actual cautery. The case which I present is, I think, an interesting one. It is a fibroma. The following is the history elicited:

Alice Todd, aged thirty-two years, came to the University clinic complaining of female trouble. Menstruation regular, slightly painful, three to five days in duration, amount of blood lost normal. Has had four children, the last one fourteen years ago. Has had two miscarriages, the last two months ago. All of her labors natural. General health good.

Examination reveals a tumor protruding from vulva. It is two inches in length, and is attached to the posterior half of the meatus urinarius. It is lobulated, smooth, dry, elastic, and painless. The urethra is very sensitive, and an attempt at catheterization occasions great pain. She states that she has no pain on micturition, sexual intercourse, or any other symptom traceable to the growth. She says she first noticed the tumor two years ago, at which time it was as large as at present. If the statement is true, she certainly gives herself little

concern about her genito-urinary organs. As it causes no inconvenience, she refuses to have it removed, fearing she might not be able to pursue her avocation as washerwoman. Except that it is unsightly and may eventually cause trouble by its increase in size, no interference is necessary. She has consented to come to-night that you may examine it and express an opinion as to its nature, the prognosis and treatment.

LOUISVILLE.

Reports of Societies.

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.*

Stated Meeting, July 21, 1893, Dr. T. L. McDermott, President, in the chair.

Dr. A. Schachner—visiting: (Myoma of Uterus; Operation; Recovery.) No. 1. Myoma of the uterus removed from a patient thirty-five years of age. She has had this growth, her physician, Dr. Eckels, tells me, for about three years. The adhesions were confined to the posterior portion of the tumor. The growth was removed and the pedicle treated extra-peritoneally. The patient made a very nice recovery. I am under obligations to Dr. Cecil for assisting me in this operation. For the first few days the bowels were a little troublesome and obstinate, but this feature was finally overcome by high enemas of fresh ox-gall. The stomach was in such a condition that it would not retain any of the salines. Several purgatives were administered hypodermatically, which did not seem to have any effect. High injections of ox-gall with some sulphate of magnesia finally relieved the bowels, and from that time on she had no further trouble. The uterus weighs two pounds.

(Multiple Cyst of Ovary; Operation; Recovery.) No. 2. This tumor I diagnosed as one of the uterus, but it proved to be a tumor of the ovary, and I judge it to be a multiple cyst. The reason I took it to be a myoma or fibroma of the uterus was that the clinical history pointed to this conclusion. The patient had uterine hemorrhages, and the position and manner in which it fixed the uterus led me to believe that it was a myoma or fibroma of the uterus, and I gave this as my opinion, and was supported in this by others who had also seen the case. The

*Stenographically reported by C. C. Mapes.

tumor while in position was very firm, and so firm that the attending physician had questioned the propriety of removal, thinking that there were too many adhesions, which would contra-indicate this procedure. I suggested, however, that as the patient was a middle-aged woman an exploratory incision should be made, at least, to see what the real condition was, and if it proved as extensive as it seemed to be before the incision the operation might then be abandoned without any practical risks to the patient. A median incision was made, and I passed my hand into the abdominal cavity and down underneath the tumor to try and determine whether there were many intestinal adhesions. This created such a hemorrhage that I concluded we had better push the operation to a close. I enlarged the incision, which ran almost to the ensiform cartilage, and fortunately found no adhesions posteriorly. There was a band which anchored it to the abdominal wall one inch and a half in width and one half to three fourths of an inch in thickness; also quite extensive omental adhesions, in which the omental vessels were as large as my little finger. The adhesions were very readily separated and the tumor taken away. The time from when the incision was made until I commenced suturing was thirty minutes, and from the beginning of the suturing until the operation was completed eighteen minutes, making forty-eight minutes altogether in removal of the tumor. The woman has had absolutely no unfavorable symptom. It is the only laparotomy of this character I have ever seen where the patient never vomited even once. She had some little nausea about the third day. I gave her a whole bottle of citrate of magnesia at one dose. This was very effective, and produced such colicky pains that morphine one eighth grain had to be administered. Sutures were removed on the fifth day, and the wound had united throughout to the pedicle by first intention. The pedicle of this tumor was also treated extra-peritoneally. It was drawn out, the peritoneum was stitched around it with silk, the pedicle was ligated with silk, and hysterectomy pins placed in the stump for support. It is now almost two weeks since the operation, and I think I can safely say that recovery is assured. I saw her last night, and the case seems to be running a perfectly normal course, and the pedicle, which is entirely without the peritoneal cavity, is commencing to give way nicely, so I can safely call it a recovery. The tumor weighs fourteen pounds. Several physicians saw the case before the operation, and estimated that the tumor would weigh about twenty-five pounds. I estimated it at

twenty pounds, and the result shows how deceptive these growths are. We often read of one hundred pound tumors, but I think in many instances this is an exaggeration. I mean to say that one hundred pound tumors of the abdominal cavity are an extreme rarity. I believe they are very much oftener reported than they really exist.

I have a case now which is being prepared for operation, in which I do not think the tumor will reach seventy-five pounds, and if it reaches sixty-five pounds I will be a little surprised. I first made a diagnosis in this case of unilocular cyst, but I will say that several gentlemen had seen the patient before me, and they all made the same diagnosis. I say this with no discredit to them, as the woman would not submit to a thorough examination, the examination being made through a thin wrapper and only by palpation, and she refused operation until her condition reached such a desperate stage that she finally consented on the bare chance she still had of recovery. I had her removed to the infirmary, it taking about two and one half hours to get her there, and made a small incision, when a large mass was visible, something like the tumor presented in the last case. I inserted a trocar into the tumor, but found nothing. I incised the tumor about an inch and a half deep, and examined it with my index finger, but still got nothing. Her condition was such that I did not care to push the operation further, and sent her home. She had at the time of the operation a pulse of 130 to 140, and went on the table with this. Six months afterward I saw her with a pulse of 80, and told her I would like to make another examination, as I could not make myself believe that there was not a cyst. I told her I would like to introduce the aspirator needle. I introduced the needle and drew off three gallons of fluid. Returning in about ten days, I drew off two gallons minus one pint and a half, making a total of five gallons minus one pint and a half of fluid, which still left her with a tremendously enlarged abdomen. The measurement of this young woman was fifty-two inches around the largest diameter of the abdomen, the tumor reaching to the ensiform cartilage. Dr. Howard Kelly, who also saw the case, said that while he had seen some larger he thought it about as large as the abdomen could get. This tumor I could easily estimate at one hundred pounds, and not create much excitement, still I do not think it will reach one hundred pounds nor seventy-five. I have carefully weighed all of the fluid withdrawn, and will be able to determine accurately in the end how much the tumor weighs.

DISCUSSION.

Dr. W. L. Rodman: Dr. Schachner is to be congratulated on the good results obtained in these two cases. I think as he does, that the large tumor he showed will prove to be more largely solid than cystic. It seems to be a fibro-cystic growth.

Dr. J. L. Howard (Case of Precocious Development): This is a little girl eleven years of age, who has a good family history; her hygienic surroundings are not good. About a year ago she suffered a great deal of pain and tenderness over the mammary region. About the first of June she had distinct hystero-epileptic attacks, very marked motor convulsions, general opisthotonos, etc. I did not see her until she had had three or four of these attacks. Soon after the first attack she had a hemorrhage from the bowels; without any fecal evacuation she would have several small stools, probably one half dram of blood each time, mixed with a good deal of mucus. At first I thought it was a case of membranous enteritis. Whenever she would have one of these attacks it would be preceded by a hystero-epileptic attack, and at the same time she would have this marked tenderness over the mammary region, very painful to the touch. About this time I also noticed a swelling over the mammary region. You will notice she is very poorly developed for her age, and I thought the case would be one of some interest. Dr. Bullock has seen the case with me. It looks like a case of precocious development. She is still having the peculiar attacks; passed some blood to-day. This hemorrhage from the bowels recurs about every two or three weeks without any regularity, lasting probably from twenty-four to thirty-six hours. There is now some swelling of the mammaræ, but sometimes it is more marked. She has had scarlet fever, measles, whooping cough, and all the diseases peculiar to childhood. I was not able to determine what the attacks were until finally I saw her in one.

The question in my mind has been whether this condition of the mammary glands had any thing to do with the hemorrhages from the bowels. They will run their course of twenty-four to thirty-six hours in spite of any thing I have been able to do. No microscopical examination has been made of the stools, but the material has the appearance of stools in membranous enteritis. The patient is very anemic, as you see.

DISCUSSION.

Dr. T. S. Bullock: The mammary glands are not nearly so much enlarged or engorged as when I saw the patient about two weeks ago. I have taken considerable interest in the case from the fact of the periodical loss of blood from the bowels, and have been somewhat puzzled to determine the nature of this hemorrhage. The only conclusion that I could arrive at was that it was one of those extremely rare cases of precocious development.

Dr. D. T. Smith: I would like to ask Dr. Howard his reasons for pronouncing the convulsions hystero-epileptic. Hystero-epilepsy is quite a violent affection, and outside of France is rather rare.

Dr. Howard: I simply pronounced them hystero-epileptic for the reason that they were so violent, much more so than hysterical attacks. When these attacks come on she will fall down just as we know people do in epilepsy, but she does not froth at the mouth. The attacks simulate epilepsy to such a marked extent that we could not tell the difference until we tried to rouse her. At one time I started to give her chloroform, and she immediately came to herself. After that I only had to talk to her of administering chloroform, and she would return to her senses.

The essay was read by Dr. Thomas S. Bullock; subject, Urethral Growths, with a Case. [See page 263.]

DISCUSSION.

Dr. J. G. Cecil: This is such a rare growth, so unlike any thing I have ever seen, that I really have no opinion about it. I believe, however, that it ought to be removed with the knife, and I think it will require a microscopical examination to determine the exact nature of it. The question has arisen as to whether this is a tumor of the urethra or not. The base of the tumor occupies or about covers the space between the meatus and the anterior vaginal wall, yet it seems to occupy or involve certainly the lower half of the urethral circle. I should judge that its character was certainly very different from that of common growths which we see in this region, and would be disposed to think that it would probably show up under the microscope as a fibrous growth.

Dr. Rodman: I think that this growth can be called a tumor of the urethra, because it is encroaching upon the lower floor of the canal, but

I do not think it had its origin in the urethra; I think it began below. I believe it will prove to be a fibrous growth. The growths that are most liable to occur in the female urethra are the ordinary carunculæ. The growths that occur most frequently in the male urethra are the ordinary papillomatous growths in the penile portion, and the true fibroid polyp, which occurs almost invariably from the prostatic urethra. This, I think, is a fibrous growth; but fibromas are very uncommon in the female urethra. They are also uncommon in the penile portion of the male urethra, being almost invariably limited to the prostatic portion. For this reason and from the appearance of the growth, I think that it began below the urethra, and has simply encroached upon it secondarily. It is an hypertrophied caruncle.

Of course the question of treatment is excision, as Dr. Bullock says, and the application of some cauter after ward. The best treatment for ordinary carunculæ I believe to be scraping off with scissors and then the application of chloride of zinc, which I prefer to all other things, and believe it is the best application that can be made. It is very fortunate that all tumors of either the male or female urethra are nine times out of ten located in the extreme anterior portion, as otherwise it would be very difficult to treat them surgically. The only exception being the fibroid polyp, which is almost always limited to the prostatic portion. Necessarily these tumors usually give rise to many distressing symptoms, pain, etc. But it is a fact that you may have tumors even deeper situated in the canal with almost no symptoms at all. I have seen a number of growths of the female urethra, but few in the male.

Dr. E. R. Palmer: The removal of the growth in the case shown by Dr. Bullock could certainly be very easily accomplished. I would suggest that it be done by cocainizing the parts, cutting it off, and the application of electro-cautery. I do not think the growth involves the urethra at all.

I do not agree with Dr. Rodman in regard to growths of the urethra. In the daily use of the urethroscope it is not infrequent that I find tumors of the male urethra situated back of the cut-off muscle.

Dr. Turner Anderson: I examined the growth under discussion at Dr. Bullock's office yesterday, and can not agree with the gentlemen who have spoken that it is not a urethral growth. When we consider that there is no space practically between the meatus urinarius and the anterior margin of the vagina, that the urethra lies in the anterior wall

of the vagina, that the meatus urinarius is simply surrounded by condensed areola tissue, we must conclude that this is either a growth of the urethra or a growth of the anterior wall of the vagina. I made a careful examination of it to determine whether it was a growth of the urethra or of the vagina, and, so far as I am able to form an opinion, it springs from the posterior semi-circumference of the urethra. Dr. Bullock has very accurately described the case, and I am convinced that it is fibrous in character.

As regards removal, there would be no difficulty in doing so, and it is not necessary to discuss that part of the question. There would be very little hemorrhage, as it is wholly disconnected with the vestibule. Operations in this situation are not attended by much hemorrhage unless we open the net-work of vessels which are recognized as the bulbs of the vestibule. I think if the gentlemen who believe that the growth is not connected with the urethra would make a more careful examination of the case, they would be convinced that this growth springs from the posterior portion of the semi-circumference of the urethra, and is fibrous in character.

Dr. W. O. Roberts: I agree with what Dr. Anderson has said in connection with the origin of the growth, and also as to the treatment. It seems to me that removal with the knife would be very much better than with galvano-cautery. I think there would be practically no hemorrhage, and the result would be better with the knife than with cautery. Experience goes to prove, in amputation of the penis, for instance, where there is liable to be very much more hemorrhage than in the removal of this growth, results are far better when amputation is done with the knife than when done with galvano-cautery, and the danger from sepsis seems to be less with the knife.

Dr. Bullock: As stated in my paper, my reasons for believing this to be fibroma was that most other growths in this situation bleed very readily on handling and are very painful. Fibromata are the only growths occurring in this situation that are absolutely painless, smooth, elastic, non-friable, do not bleed, and occasion absolutely no inconvenience unless they attain a considerable size and drag on the urethra, thus creating trouble by their weight.

In regard to treatment, if I can get the patient to consent we intend to operate upon her at the University clinic before the class, but I think we will have some difficulty in getting her to consent to the procedure. As regards the growth being hypertrophied carunculæ, it seems to me

if this had been the case she would have noticed it long prior to two years ago.

Dr. Roberts (Suprapubic Cystotomy, with Removal of Three Stones, One Encysted, from the Bladder; Recovery): The early part of June I was asked to see a case in consultation with Dr. E. R. Palmer for stone in the bladder. The patient was sixty-seven years of age and had been complaining of bladder symptoms for three years. He had been treated by internal medication for one year without any benefit, then he was treated by another physician by washing out the bladder with boric acid solution and using a catheter. He passed water very frequently, and soon after he began to use the catheter he had to use it every few hours. At the time I saw him with Dr. Palmer he was using the catheter every two hours; he had not suffered any great pain, nor did he have any marked symptoms of stone. Dr. Palmer had discovered the stone a short time before I saw the case with him. He told me at the time that he was under the impression that the stone was a large one, and most likely encysted. We made a careful examination under cocaine with a sound and came to the conclusion that there were two calculi. His prostate was examined through the rectum and found to be quite large, but there was no enlargement of the third lobe. Operation was advised, and owing to the large size of the prostate we agreed to do the suprapubic cystotomy. On the 23d of June the operation was performed at the Norton Infirmary, Drs. Palmer, Vandell, Pearce, and several others assisting. The bladder was not contracted; we could easily get into it eight or ten ounces of boric-acid solution. As soon as the bladder was opened I found two calculi, the smaller of the three here presented lying loosely in the bladder; after their removal, passing my finger high up to the fundus on the left side I discovered the largest stone presented, which you will see is very rough, the rough side of it being adherent to the bladder. After detaching and removing it there was a considerable oozing of blood. The bladder was drained for forty-eight hours by strips of iodoform gauze introduced and left hanging out of the abdominal wound. The patient has gotten along uninterruptedly well, and while he went for two years without passing any water (except by catheter), yesterday he passed naturally a small quantity.

DISCUSSION.

Dr. Palmer: The case reported is one that has interested me very deeply. I think Dr. Roberts failed to emphasize the fact that the clin-

ical symptoms of stone were entirely absent. The patient is a very charming old gentleman, but like most old men very set in his views and opinions of things; he had been assured that his trouble was cystitis and had been treated by washing and internal medication, and was very much set against instruments. He had never had the sudden cut-off in urinating, never had any pain in the glans penis. He had none of the symptoms that would point to cystic calculi. A remarkable feature of the case to me was that for eighteen months he catheterized himself about twelve times per day, about every two hours. He is the father of one of our leading druggists, from whom he had learned the virtue of surgical cleanliness. As he had not passed any water voluntarily for eighteen months and had been washed without any benefit, I told the druggist that his father must be examined with proper instruments. In passing a steel sound, No. 29 French, I was struck with the fact that as soon as I passed it through the cut-off muscle the sound almost dropped into the bladder. The posterior urethra, instead of being constricted by the middle lobe or contracted by general prostatic enlargement, was exceedingly roomy. As the sound dropped into the bladder it struck a calculus, which delighted me very much because of my belief that we could assure him of decided relief, if not complete cure of his condition. I explained the necessity for operation to both the patient and his son. Dr. Roberts was then in Omaha, and I advised waiting until he returned and then that he be called in consultation. The first stone detected was the large one in the fundus, the second stone I am certain was in the middle zone of the bladder, and the third was not found until the operation. The total weight of the calculi removed was about eleven drams; a considerable amount of material being lost with the fragments brought away by washing the bladder after the operation.

In regard to the symptoms, of course one of the best symptoms of stone is *stone*; but this gentleman presented none of the classical symptoms pointing toward stone in the bladder. While they might have been found sooner if his bladder had been examined, yet the doctor who failed to find stone is perhaps excusable for not having done so because of the fact that all the characteristic symptoms of stone were entirely wanting.

Of course the question arises whether there will be complete restoration of the powers of discharging urine. This is dependent upon the recovery of tone on part of the bladder. I believe that his frequent

catheterization has preserved his bladder tone, although he is nearly seventy years of age. I was more positive and more confident of this than was Dr. Roberts, and I believe he will recover his powers of urination. I was very much delighted last night to hear his son say that his father had passed some water and that he goes eight hours without emptying his bladder. My instructions were that when he began to feel like emptying his bladder to place his hand upon the opening, not allowing the urine to escape there, and attempt, if possible, to establish a restoration of the normal function. He, like a great many of our patients, wanted a guarantee of complete restoration, complete cure, etc.; but he says to-day that if he does not recover his powers of urination and has to go through the balance of his life with a fistulous opening, he is extremely delighted that the operation has been performed.

Concerning the question of asepsis and antisepsis, if there ever was a case in which the work was done with extreme care it was the operation in question. No one came in contact with the case except Dr. Roberts and myself, and we both cleaned ourselves most thoroughly and absolutely, instruments freshly sterilized, and every precaution taken; no towel even was allowed to be touched by any assistant, and yet twenty-four hours after the operation the patient had a tympanitic belly, great pain, temperature 99° , and we were naturally very much alarmed. However, it proved to be nothing more than ordinary flatulency of the bowels, which we learned the patient had been subject to before the operation. The man complained of nothing that would suggest the fact that he had had a capital operation performed upon him. The bladder was not seen in the operation, but in attempting removal of the largest stone the incision had to be slightly enlarged. The result in this case I am certain will demonstrate, as has been demonstrated so often, the value of absolute care in work of this kind.

I exhibited at the last meeting of this Society a young man having a serpiginous chancroid on the penis and sore in the right groin. This patient called at my office to-day, and the place in his groin was perhaps one eighth of an inch in height, if any thing a little longer than it was when I saw it two weeks ago, and certainly very much less promising in the matter of cure than it was when he was before the Society two weeks ago. He has had this trouble for more than a year, and to-day we seared the whole surface with electro-cautery. We seared the chancroid on the penis about a week ago; it is not much better. To-day

we treated it, as I am treating some tuberculous glands of the face, with creosote, with the hope that we may get the local and specific action of the creosote on any tubercle bacilli that may be at work and keeping up this trouble. The young man in question is otherwise in good health, and the sore on the penis together with the one in the groin has existed for something over a year. They have resisted every possible mode of procedure in the matter of cure that we have employed, and we have tried almost every thing.

The question has been asked as to whether we have tried bovine in the treatment of this case. These sores were dressed with bovine for a month, dressings changed every morning, but there was no improvement under its use.

DISCUSSION.

Dr. Roberts: In connection with this case, speaking of the long duration of chancroid, I saw one in a young man that existed for something over a year, and his penis was finally amputated, when complete recovery took place. Amputation was done under the impression that it was an epithelioma. I have another case now that has been in existence for eleven months. A considerable portion of the penis has been destroyed.

GONORRHEA AND THE PUERPERIUM.—Kronig (*Centralbl. f. Gynakologie*, No. 8, 1893,) has studied the development of gonococci in nine women after labor. The germs are easily found in the lochia. It is certain that in women with vaginal gonorrhea the disease may extend into the uterus during the puerperium. Gonorrheal infection of the uterine cavity may also set up fever even when there is no trace of mixed infection, no other germs being present. Gonorrheal infection in the puerperium is not of direct danger to life, but frequently leads to complications late in the puerperium, the disease progressing from the endometrium to the tubes. Two cases of this kind are recorded. The first, after the usual careful routine treatment, left the hospital on the fourteenth day. Two weeks later she returned. A perimetric exudation was detected to the left of the cervix. The second case was graver. On the fourteenth day the temperature rose to over 103°, the right elbow became painful, and effusion into the extensor tendons of the right hand occurred. During the third week right parametritis set in, the temperature rising to 104°. Then the pain and parametric swelling subsided. The fluid from the tenosynovitis was sero-purulent, but free from germs.—*British Medical Journal*.

Reviews and Bibliography.

Weekly Abstract of Sanitary Reports, Issued by the Supervising Surgeon-General, M. H. S., Under the National Quarantine Act of April 29, 1878. Vol. VII (Nos. 1 to 53). 862 pp. Washington: Government Printing Office. 1893.

This volume, in the form and dimensions it has obtained, is one of the witnesses, now all too many, of the lavish extravagance to which our Government has drifted. In every one of its vast departments each chief will as far as possible magnify his office by securing the publication of extensive and profitless reports, more profitless read than unread, and thus contribute a share to the burdens of the tax-payer.

Will any one inform us why our Government shall go to the expense of publishing the total deaths for May in Paramaribo, when outside of influenza not one of them is from a contagious disease; or that nine deaths occurred in Malta and Gaza in the month of May from measles? We shall expect next that the agricultural department will be sending out advice that the trees began to bud in Senegambia on such a date, and that on such a date berries began to ripen in North Australia.

For every purpose of science or hygiene an abstract of this work might be made that could be published in a vastly smaller compass. It would then have both interest and value.

D. T. S.

Diseases of the Rectum and Anus: Their Pathology, Diagnosis, and Treatment. By CHAS. B. KELSEY, A. M., M. D., New York, Professor of Diseases of the Rectum at the New York Post-Graduate Medical School and Hospital; late Professor of Diseases of the Rectum, University of Vermont, etc. Fourth edition, revised and enlarged. With two chromo-lithographs and one hundred and sixty-two illustrations. Octavo, 496 pages, extra muslin; price, \$4. New York: William Wood & Company. 1893.

After a thorough revision, in which the work has been brought fully up to date, the fourth edition of this standard authority is offered to the profession. The work throughout evidences the master. It bears on every page the stamp of large experience, of judicial fairness and profound thoughtfulness. The author has evidently no hobbies or pet theories calculated to lead his judgment astray. His teachings in regard to the two diseases that occupy the foremost place in affections of the rectum, viz., fistula and hemorrhoids, are especially exhaustive. As to selection of subjects for operation in fistula, he would discriminate cautiously in cases of Bright's disease, cancer, cardiac and hepatic affections, and with somewhat larger latitude in tuberculosis. But the valuable feature of the treatment of this subject is the caution he enjoins in the prevention of harassing after-effects in operations involving the entire sphincter.

In the treatment of hemorrhoids the author is persuaded that the clamp and cautery method of Smith is in many instances superior to ligation as advocated by Allingham. In the treatment of cancer of the rectum by operation the author's views command the approval of fair-minded men. As a rule, in the very nature of things the operation is hopeless, and even in the so-called statistics, one-sided as we know these to be, no justification is to be found. There is little reason to doubt that the total of life in such patients is greatly diminished by such operations, and he who operates merely to display the brilliancy of his cutting skill, or for the sake of a fee, has not even the excuse of the highwayman.

In addition to the soundness of the author's teachings, a feature of the work that perhaps above all commends it to the average reader is the graphic character of description and the general attractiveness of style that makes the book easy and pleasant reading. It is a work that should be in the hands, not of the specialist only, but of the general practitioner, especially in districts remote from the large cities, if for nothing more than to enable him to give enlightened and correct advice.

D. T. S.

A Text-Book of Medicine for Students and Practitioners. By DR. ADOLPH STRUEMPELL, Professor and Director of the Medical Clinique at Erlangen. Second American edition. Translated by permission from the second and third, and thoroughly revised from the sixth German edition by HERMAN F. VICKERY, A. M., M. D., Harvard, and PHILIP COOMES KNAPP, A. M., M. D., Harvard, with Editorial Notes by FREDERICK C. SHATTUCK, A. M., M. D., Professor of Clinical Medicine, Harvard University. One hundred and nineteen illustrations. 1043 pp. New York: D. Appleton & Co. 1893.

This text-book, which in the first translation had already been adopted as a book of reference in twenty-eight American colleges, now appears in a new dress and with many features of improvement. We have already, in reviewing the former translation, spoken of it as a classic.

It is not, perhaps, so much stamped with the genius and individuality of the author as were the great works of Watson, Trousseau, and Niemeyer, long since relegated to the shelf by the rapid march of medical science, but only with them is it to be compared in its relative position, while its actual position is as far in advance as the science of to-day is ahead of the science of the past.

The great work of Eichhorst, of those translated from the German, is the only one to be placed in the same class with it; while of works by American authors Osler alone, in our opinion, can dispute with it in the claims of position. In freshness of style, in the flow of description, it is perhaps not equal to Osler, but it is planned upon a perceptibly higher scientific level.

With most of the first-class works of recent date from the German, the advantage of short sentences and uninvolved periods seems to have found recognition. This is eminently the case with the work in hand. The genius of the German language allowing it, German authors have for the most part too freely indulged themselves in complex and involved sentences, and taxed

too much the mental powers of the reader in gathering the meaning of the author, thus detracting from his ability to comprehend the subject-matter of discourse. The translation has been excellently made, and will compare favorably with any other work of the kind anywhere to be found.

It is a book, taken all in all, not to read but to study, and deserving to be held not in the attitude of an acquaintance, but as a companion.

D. T. S.

Letters from a Mother to a Mother on the Care of Children's Teeth. By MRS. "M. W. J." 114 pp. Published by the Wilmington Dental Manufacturing Company. Philadelphia: 1893.

These letters are a quasi-scientific appeal to civilized humanity to patronize the family dentist. There is much in it of real scientific interest, and much more that is of a speculative nature.

Attention is given to the question of the early decay of the teeth among civilized races, but it seems to us that no progress is made toward a solution. Directing what food the mother shall use, and especially that she shall drink lime-water during pregnancy, reminds one of and is of a piece with the folly of feeding the mother on vegetables to give the child a soft cranium at birth, thus making birth easy. It seems not to have occurred to these people that many animals eating fruit and vegetables alone bring forth their young with harder bones, and having teeth at an earlier age and better than those fed on the most approved food. There can be little doubt that the millstone has in the progress of civilization taken away much of the work of the teeth and left them to decay. The concentration of food also has likely done its share.

To reach the right solution of the question we can not justly do less than contrast the points wherein the rule of savage life differs from life under civilization, and these "Mother" in this plea for a larger patronage for the dentist has not done.

D. T. S.

System of Diseases of the Ear, Nose, and Throat. Edited by CHARLES H. BURNETT, A. M., M. D. Volume 1—Diseases of the Ear and Diseases of the Nose and Naso-pharynx. J. B. Lippincott Company. 1893.

This is a book that has been extensively advertised, and from which much was to be expected, and in which many will be disappointed. The portion devoted to the ear consists of thirteen chapters by different authors, some of which are good, others rehashes of medical journal articles, others indifferent. It is not an exhaustive study of ear diseases, and in this particular can not be compared with the more prominent text-books, such as those of Politzer, Gruber, Roosa, etc. It will be of some interest to specialists, but of little to students and practitioners. To specialize, the chapter on the anatomy of the ear is by far the best, and will fully repay for the price of the book. The nose and naso-pharynx are dealt with in ten chapters, the best of which is the one on the anatomy and physiology of the nose and naso-pharynx. The book is an attractive volume, and I would advise the specialist to obtain it.

J. M. R.

Abstracts and Selections.

SUBDIAPHRAGMATIC ABSCESES CONTAINING AIR.—Vanlair (*Revue de Medecin*, July, 1893,) relates a case in a boy aged six years. The illness began with a generalized entero-colitis, with a tendency to localize itself in the region above the umbilicus, where there were some signs of a local peritonitis. Then a right pleural effusion occurred, accompanied by a painful swelling in the epigastrium. This latter increased rapidly, and yielded three days later a tympanitic resonance, a murmur coincident with respiration and metallic tinkling being also present. About the same time a pneumonia appeared on the left side, and three days later an encysted pneumothorax on the right side. A crural phlebitis and epigastric periphlebitis also supervened. An operation performed one month after the onset revealed (1) a purulent pleural effusion, (2) perforation of the diaphragm, (3) a subphrenic abscess, (4) a perforation of the colon, as well as a perforation of the pleura. The subphrenic abscess was incised and drained, a counter-opening being made in the pleural cavity, and the intestinal opening was stitched up. The boy recovered. As to the sequence of events, the author believes that the peritonitis started from the intestine, that the pleurisy excited at the right base soon became purulent, that a limited destruction of the diaphragm, and subsequently of the pulmonary pleura, gave rise successively to a subphrenic abscess properly so-called and a pneumothorax, and that the intestinal perforation was a secondary and not a primary lesion. The author does not believe that the perforation of the diaphragm led to the production of the empyema, for the clinical development was against it. In discussing the question of the presence of air in the subphrenic abscess, the author thinks that here it came from the intestine. The differential diagnosis between the real and pseudo pneumothorax is considered. The prognosis must be generally looked upon as unfavorable. Rarely are so many complications present as in this case. The author concludes that, (1) Subphrenic abscess containing air may occur in children; (2) it is not always due to a suppurative process or localized ulceration (the cause here being an entero-colitis); (3) the intestinal perforation may be a secondary result; (4) the symptoms may be limited to pain and an epigastric phlegmon; (5) any of the above named complications, including phlebitis, may occur, and indeed all in one subject; and (6) operative procedures, with thorough antiseptics of the surfaces, should always be had recourse to, and recovery may occur even in unfavorable conditions.—*British Medical Journal*.

THE SIGNIFICANCE OF VAGINAL DISCHARGES.—A leucorrhea inodorous or of mild odor persisting during the climacteric, accompanied by increasing hemorrhage, is suspicious and demands investigation. A leu-

corrhea profuse, of peculiarly fetid odor, grumous, excoriating, appearing early or late during the climacteric, with profuse hemorrhage, is reasonable evidence of cancer of the cervix. A leucorrhea moderate in amount, ill-smelling (the peculiarly fetid odor of cancer of the cervix being absent), accompanied by hemorrhage, suggests cancer of the corpus uteri. A leucorrheal discharge with hemorrhage containing material like the washings of meat is said to indicate sarcoma. A watery discharge, as a rule, occurring during menstruation, odorless, or of little odor, persisting, accompanied by profuse hemorrhage, indicates fibroids; with little or no hemorrhage, polypi. Profuse bloody discharges coming on gradually with declining menstruation, ceasing usually with the menstrual flow, point to fibroids. Persistent profuse discharges of blood occurring spontaneously, arising from sudden exercise or coition, occurring as a rule after the menopause, indicate cancer. A gradually increasing amount of menstrual flow is suspicious and needs investigating. Post-climacteric hemorrhages in a fibroma of the uterus of long standing form one of the principal grounds for the suspicion of sarcoma (Borner). The early recognition of malignant disease is demanded, and possible prevention of the fatal exhaustion which accompanies it by the administration of drugs, and the application of those methods which in a measure may be supposed to offset the terrific drain on the nervous system; inasmuch as present experience shows that early removal of diseased tissue prolongs life, the importance of early diagnosis and treatment can hardly be overestimated.—*New England Medical Gazette.*

METHYLENE BLUE IN CANCER.—A. d'Ambrosio, Professor of Clinical Surgery in the Hospital for Incurables at Naples, reports (*Rif. Med.*, June 3d) the following case: A woman, about fifty years of age, had a tumor in each breast. That on the right side, which had almost entirely replaced the mammary gland, was ulcerated, and hemorrhage was frequent. Numerous secondary nodules were scattered around the principal mass, giving rise to the appearance sometimes described as "lenticular cancer." The microscopic examination of fragments removed for the purpose revealed the appearances characteristic of carcinoma. Amputation being out of the question, one gram of one half per cent solution of methylene blue was injected into the tumor every day, the ulcerated surface being dressed with one-per-cent solution of the same substance. Within a fortnight of the commencement of treatment the pain and hemorrhage ceased and the tumor had shrunk in size. In four months it had disappeared, together with some enlarged glands in the axilla and numerous nodules in the skin around the breast. In place of these, however, several new nodules had formed. In the mean time the tumor in the other breast had grown considerably, and was removed. She was readmitted to the hospital some time afterward with pleurisy of the left side (which had been the seat of the ulcerated mammary tumor); there appears to be no evidence, however, that this was due to extension of the malignant disease. Of the tumor itself nothing remains

but a firm lardaceous cicatrix partly covered by blackish crust with a few cutaneous nodules, which disappear and form again according as the injections are given or withheld. D'Ambrosio thinks the treatment in this case has certainly prolonged the patient's life more than a year, and notwithstanding the unfavorable conditions he does not despair of a complete cure. *British Medical Journal.*

VARIOLIFORM ERUPTION AFTER VACCINATION.—Marchoux, in a report on vaccination in Indo-China (*Rev. d'Hygiène*), relates three cases of varioloid, or varioliform eruption following vaccination with vaccine obtained at the Vaccine Institution at Saigon, where buffaloes are used for vaccinifers. This vaccine is otherwise known to possess an exalted virulence. (1) At the same time as the vaccine pocks developed in a child there developed also about fifty umbilicated pocks on various parts of the body. The child had some backache and a little fever. (2) A child presented twelve umbilicated pustules, which developed at the same time and rate as the vaccine pocks. The fever was considerable. (3) At the same time as the vaccinal pustules appeared to develop on an adult male, numerous other spots appeared, and he finally presented about one hundred pustules scattered over the body. The fever was considerable; he was delirious and confined to bed. Inquiry in each case failed to elicit any evidence that the patients could have been exposed to infection of smallpox.—*British Medical Journal.*

PLACENTA PRÆVIA.—Tarnier (*Jour. des Sages Femmes*, June 1, 1893,) demonstrated in May a case which he held to be highly instructive. On May 10th a sempstress, who had been delivered normally thirteen times and was approaching term, sent for the midwife, as great edema of the extremities had set in. On the 14th hemorrhage occurred, and recurred severely on the 15th. The midwife diagnosed placenta prævia, and immediately plugged the vagina with strips of the cotton dresses which lay about in the patient's room, dipping them first in sublimate. Tarnier declares that as time was pressing she did right, though rupture of the membranes would have been best. The stuff employed was of course not absorbent cotton, and free flooding occurred in the night; the midwife plugged the vagina again, and the patient was sent into hospital. M'lle. Landais, the hospital midwife, found that there was no more bleeding, so left the case at rest. Strong pains occurred very soon, and about two hours after the application of the second tampon a single uterine contraction expelled "in half a minute" the tampon, membranes, child, and placenta. The infant was dead, the mother little the worse for her dangerous labor. Tarnier notes that the hemorrhage might have been attributed to the conditions which caused the edema. There was no albuminuria. He does not, as is above explained, condemn the tampon in placenta prævia, there being no fear that the plug might change external into internal bleeding. Clots form behind the plug and tend to close the open vessel.—*British Medical Journal.*

THE AMERICAN PRACTITIONER AND NEWS.

"NEC TENUI PENNÆ."

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No. 7.

D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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WILLIAM H. GALT, M. D.

This genial gentleman and popular physician died suddenly on the 14th ult., at his home in Louisville. Dr. Galt was a member of one of the oldest and most prominent families of Kentucky, and, having lived the greater part of his life within a few miles of the place of his birth, few men were better known in this community. He was born April 23, 1827, at Repton, in Jefferson County. He was the oldest child of Dr. Norborne Alexander Galt, and grandson of Dr. William C. Galt. His mother was Miss Elizabeth Gray, the daughter of John Thompson Gray and Mary Ormsby Gray.

He graduated from the Kentucky School of Medicine in 1853, and, going to Daviess County, practiced his profession until 1858, when he returned to Louisville, where he lived till the breaking out of the Civil War, when he entered service in the Confederate Army as surgeon in Colonel R. Butler's regiment. He was made prisoner and taken to Camp Chase, Columbus, O., where he remained until paroled. After the war he practiced medicine in Louisville until about twelve years ago, when he was elected Health Officer. About the same time he became Professor of Theory and Practice of Medicine in the Louisville Medical College. For a number of years he was medical director of the Mutual Life Insurance Company of Kentucky.

Dr. Galt was for several years associate editor of the Louisville Medical News, which he founded with the late Dr. Richard O. Cowling

in 1876. In the famous Gaillard School controversy of twenty years ago Dr. Galt took an active part, and some of the keenest thrusts were inspired by his fine wit.

Dr. Galt married Miss Elizabeth Thruston Pope, the daughter of Patrick H. Pope. He was the father of seven children, most of whom survive him. Though somewhat melancholy and retiring in disposition, few men were more genial and sunny in manner to those who knew how to approach him. Dr. Galt was a brilliant and scholarly physician, a clear teacher, a sincere friend, a Christian, and a gentleman.

THE MILK SUPPLY AS A SOURCE OF INFECTION IN TYPHOID FEVER.

It is interesting to note the many recent reports of typhoid epidemics resulting from milk supplies. Health officers should, besides examining localities as to their sanitary conditions, pay more attention to bacteriological experiments, which give a degree of certainty and permanence furnished by no other methods.

Dr. Wyatt Johnson, in the *Canada Medical Record* of August, reported a recent typhoid fever epidemic in Montreal, the undoubted origin of which was by infection through milk supplied by a well-known dealer there. The epidemic, though not very extensive, attracted considerable attention, the mortality being up to the average in typhoid (three in twenty). Dr. S. M. Mouser, in a paper read before the San Francisco Bacteriological Society, reported the following conclusive instance:

About the 15th day of May last a case of typhoid fever occurred at Reyes' dairy, which is situated a few miles northeast of Oakland, and from which many Oakland people drew their supplies of milk. Soon after this another of the dairymen came down with the fever. Some quarrymen working in the immediate vicinity, not using the milk, but drinking water from the tank used for washing cans, were taken sick with the disease, one or more of whom died.

About the middle of June several cases were reported by Dr. Todd in the heart of Oakland, and on inquiry it was ascertained that they were all using milk from the Reyes dairy. From this time on the disease spread with great rapidity, as high as seventy-five cases being reported to the Oakland Health Office in a single day. Three hundred and sixty-two cases

were reported altogether in less than a month from the time that the first cases occurred in the city. Of these, two hundred and twenty-eight were positively known to have been patrons of the suspected dairy. In twenty-two cases the source of supply could not be ascertained, and the rest of the cases were supplied from thirty-four dairies. About seventy per cent of the cases were known to have used milk from Reyes'. In a house of two flats the family living in the upper one consisted of six persons, five of whom used milk from Reyes', and all had fever. One used no milk and escaped. In the lower flat the people received their milk from a different source and were not sick at all.

Dr. Mouser further gives the bacteriological analysis of the water supply of this dairy, made by himself, and demonstrating almost beyond a doubt that this was the source of infection. A chemical analysis made by the State University strongly condemned the water.

Notes and Queries.

RELATIONS OF DYSPEPSIA TO PULMONARY TUBERCULOSIS.—At the French Congress for the Study of Tuberculosis recently held in Paris, one of the subjects discussed was that of the relationship of dyspepsia to pulmonary tuberculosis.

Marfan has maintained in his thesis that the digestive disturbances of the phthysical bear the relation not of cause but of effect; in other words, they are but one of the manifestations of the tuberculosis. Often the dyspepsia masks the tuberculosis. Marfan believes the initial dyspepsia to be caused by a "humoral state."

According to Hayem, whose paper attracted much notice, the gastritis of the phthysical is a common gastritis due to the ordinary causes of stomach inflammations. It is generally accompanied with retardation in the evacuation of the stomach and consequently with dilatation. It sometimes precedes for several years the appearance of the tuberculosis, and is only exaggerated at the outset of the phthisis in patients who take excitant drugs or who adopt a regimen not adapted to the state of their stomachs.

The causes of the gastric affections of the phthysical are those of ordinary gastric affections, to wit, the abuse of tobacco and alcohol, errors in diet, etc. It is a mixed gastritis, parenchymatous and interstitial.

In one case Hayem found, at the autopsy, a general amyloid condition of the entire mucosa; in another, a necrosis due to a thrombosis; exceptionally, he has met with a tuberculous ulcer.

A gastropathy of uncertain source begins early in life; it entails a state of general debility, and at a certain moment pulmonary tuberculosis bursts forth. The physician then institutes an active treatment based on super-alimentation and the abuse of medicaments.

Under the influence of this particular regimen, continued for months, there supervene the symptoms of violent gastric catarrh, in other words, the "initial gastric syndrome" of Marfan. It is simply the exaggeration of a gastropathy which had existed for many years, sometimes fifteen or twenty years before the appearance of the pulmonary accidents. Under a suitable dietary regimen and the suppression of medicines these gastric symptoms vanish.

When the attending physician discards the administration of irritant medicines and prescribes nourishing, easily-digested food, he will, even in febrile cases, see the condition of the stomach improve.

The tuberculosis at the onset, then, does not make the state of the digestive organs evidently worse. On the contrary, there are few diseases which so rarely affect the stomach. One is often astonished at the digestive capacity of the phthisical, who will eat more nutritious food than a well man.

In concluding, Hayem said that with the exception of rare lesions, ulcerations, amyloid degenerations, etc., the gastritis of the phthisical is of the common kind.

It is sometimes latent, and is not diagnosticated before the appearance of the tuberculosis. It should, nevertheless, be a subject of preoccupation by the medical attendant, for this gastritis may end in grave gastropathies, and open the door to pulmonary tuberculosis. In hospital patients it would seem that chronic alcoholism is a frequent cause of gastritis.

One of the best means of warding off pulmonary tuberculosis in the predisposed consists in treating the gastropathy.

The proper medication addressed to the digestive tube may perhaps in some subjects arrest tuberculosis at the onset.—*Boston Medical and Surgical Journal*.

ARSENIC IN EPITHELIOMA.—Lassar (reprint from *Berl. klin. Wochenschrift*, 1893,) reports his success with arsenic administered internally in four cases of epithelioma affecting various parts of the face. Case 1 was a man, aged fifty, with three large swellings occupying one orbit, the nose and the chin respectively. Microscopic evidence showed epithelial cells, spindle cells, and alveolar structure. Immediately after the administration of arsenic the three growths gradually diminished by drying up, involution, and cicatrization, until the youngest growth had disappeared and the second one cicatrized. The largest and oldest growth, occupying nearly the whole of the orbit, showed little change, and owing to the suggested excision of the eyeball the patient withdrew from treatment, and is believed to have died subsequently. In a second case, that of a woman of advanced

age with a smaller growth on the nose, a great reduction in size took place, and the patient, being satisfied, also ceased to attend. The author now resolved to adopt the same measure with recent growths instead of at once resorting to the knife. The first patient had on one cheek a growth equal to half a walnut, which had taken six or eight months in developing. Only a slight erosion of the surface was present. The diagnosis was confirmed microscopically, and arseniate of potash was administered three times daily for two months, when the growth had shrunk and cicatrized. The next patient was a man with a similar growth of three months' standing on the left ala nasi, the condition and proofs being the same. Fowler's solution was given internally, accompanied at first by subcutaneous injections. These being painful were discontinued, and in two months complete disappearance with cicatrization followed. The author admits the small number of cases experimented on, but lays stress on the striking and indisputable results. Illustrations of the patients at various times and of the microscopic sections are given.—*British Medical Journal*.

THE SUN IN SURGERY.—Dr. D. V. Thayer, of San Francisco, after trying heated needles, endermic needles, croton oil, Baumgartism, and caustics, has come to the conclusion that the solar rays are the most efficient of all surgical methods in the treatment of "capillary aneurisms, varicose veins, indolent, chancroidal, and rodent ulcers, epithelial cancers, birth, India-ink, and powder marks, bleeding vessels and surfaces, hemorrhoidal and erectile tumors, morbid growths, such as warts, moles, small wens, and all diseases of the skin of a parasitic nature."

This is claiming a good deal for the sun, which, though a large and important body, has not heretofore made any pretences to surgical pre-eminence. Dr. Thayer admits that he is not the first to discover the surgery and dermatology of the sun. Some years ago a London surgeon, by using the sun's rays, succeeded in removing a wine-mark from the face of a lady, and also succeeded in destroying a malignant growth with the same remedy. The wound healed readily, and up to the time the article was published there had been no symptoms of the disease returning.

Dr. Thayer does not seem to know of the improved methods of using the sun devised by Count Mattei. That ingenious old gentleman bottled up the solar rays and sold them in solution, to be taken internally *ter in die*. However, the San Francisco physician seems just as confident of his more open procedure. He says (*Pacific Medical Journal*): "During a practice of more than a quarter of a century I have found no caustic or cautery to compare with solar heat in its beneficial results. Unlike other caustics, it can be applied with perfect safety upon the most delicate tissues, and is at all times under the control of the operator. It has other advantages: the system receives this treatment kindly; the irritation and inflammation following its application are surprisingly slight and of short duration. Another point in its favor, the pain subsides immediately upon the removal

of the lens. I have burned the skin of nearly the whole of one side of the face at one sitting, destroying the cuticle: within five minutes the burned surface would be free of pain. There is a curative power in the chemical rays of the sun yet unexplained. I avoid blistering, carrying the burning beyond this point, carbonizing the tissue."

Dr. Thayer tells us of his wonderful results, but does not describe his technique. Hence we grow somewhat suspicious, and are less surprised to hear his admission that he has been called a quack.

We find nothing of quackery in his article, but it is difficult to understand how thermic rays from the sun have a different therapeutic effect from those of an electric cautery.

The specialty of using the sun in surgery will, at any rate, be confined to the Pacific coast, where the sun shines every day in the year for nothing. *Medical Record.*

CONSERVATIVE OPERATIONS ON THE OVARIES, TUBES, AND UTERUS.—A. Martin (*Deut. med. Wochenschrift*, July 27, 1893,) draws attention to the importance of this subject. (1) Resection of the ovary. Ovarian disease is very frequently bilateral, but sometimes circumscribed cystic disease may be found in the other ovary. The question arises as to whether the whole organ should then be removed. It certainly should be if there is no healthy ovarian tissue left or the process be a suppurative one, but in some other cases it may not be necessary to remove it. The author refers to twenty-seven such cases with one death; two of these relapsed, and of the twenty-four remaining ones eight bore children. Ignipuncture has been employed, but the author is satisfied with incision and stitching up. (2) Resection of a stenosed tube, the other being removed for disease. Here it may be more difficult to recognize the character of the disease. The contents of the tube must be most carefully looked to. If the contents be turbid or unmistakably purulent, or if the mucous membrane be ulcerated, the tube must be removed, otherwise resection with the formation of a new ostium may be practiced. If any doubt exists, the whole appendage must be taken away. Of forty cases with two deaths, only four were not cured or considerably improved. Only one became pregnant, but twelve were unmarried, and the husbands of some others were neurasthenical or had had gonorrhea. (3) Enucleation of myomata. The older the patients the more likely are myomata to be multiple. In one hundred and forty-one cases of intraparietal myomata twenty-six died, but this includes the period of development of the *technique* of laparotomy. Of the last twenty, only one died. Of the one hundred and fifteen, only four relapsed (three per cent). The author has not found any difficulty in stitching up the bed of the tumor, nor has unpleasant hemorrhage occurred. Only two of these patients became pregnant, but other causes of sterility may exist. The author concludes (1) that the conservative operations do not present any materially greater risk than radical ones, (2) that women are thus relieved of their

troubles in by far the greater majority of cases, (3) that relapses are exceptional, (4) that the female functions persist, (5) that child-bearing is possible, and (6) that childbirth then takes place without any special risk.—*British Medical Journal.*

QUARANTINE as generally practiced in times of panic is brutal and inhuman. As cholera is not indigenous to this country, rigid inspection at our ports of entry is of the greatest importance. Separate the sick from the well, keep suspects under surveillance, destroy infected clothing and other articles, and keep discharges of cholera patients from entering water supply, and the disease can not prevail in this country. Inland quarantine is a delusion and a snare. Let each community observe the ordinary laws of hygiene, looking especially to a pure, uncontaminated water supply, and there need be no fear of the disease. Cholera is a water disease. It may be drunk or taken into the alimentary canal by food, but it can not be caught. It is hoped that we shall never have a repetition of the barbarities practiced in New York harbor last year.

OUR friend and contributor, Dr. J. Fulton Purdom, has changed his office from 910 West Jefferson Street to 1505 West Walnut Street, Louisville, Ky. We hope that the new location means increase in business, and such reflex cerebral irritation as will soon result in a new paper for the *American Practitioner and News*.

Special Notices.

WITH the pure hypophosphites of lime and soda you can score success time and again. The results are gradual, steady, and certain if the remedy is persevered with faithfully, until the cure is complete. None but chemicals of known genuineness and absolute purity should be used. McArthur's Syrup is prepared on the principle laid down by Dr. Churchill. It contains the chemically pure hypophosphites of lime and soda, uncomplicated with other drugs, in a pure and wholesome syrup. If you would like to study this subject more closely the McArthur Hypophosphite Co., Boston, Mass., will send you, free, a pamphlet on "The Treatment and Curability of Consumption."

FOR BRONCHITIS.—

| | | |
|---------|-------------------------------------|------|
| R | Neurosine, | ℥iv; |
| | Syr. senegæ, | ℥ij. |
| M. Sig: | Two teaspoonfuls every three hours. | |

DR. CARL KOLLER, of Vienna (now at 32 East Sixtieth Street, New York), through whose discovery Cocaine was first introduced into medicine in 1884, says:

"I have used MURIATE OF COCAINE ('BOEHRINGER') for some time in my practice and have achieved entirely satisfactory results through its physiological action. I found it to be a chemically pure preparation, and have never observed any foreign and deleterious effects in its use."

THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNĀ."

VOL. XVI.

LOUISVILLE, KY., OCTOBER 21, 1893.

No. 8.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

INTESTINAL ANASTOMOSIS BY A NEW DEVICE.*

BY H. HORACE GRANT, M. D.

Professor of Surgery, Louisville Hospital College of Medicine.

A word only is needed in the presence of this Society to indicate the paramount importance of establishing some satisfactory technique of intestinal anastomosis. It has come to be recognized that the operation has no substitute, and also that even in situations specially suited to them neither enterorrhaphy nor implantation are to contest for election. The older history of the operation is of little value, and the recent methods are familiar to you all. After considerable experimental work on dogs I found the anastomotic opening, 1 inch to 1¼ inches, could be established in small animals in from 15 to 25 minutes with almost uniform success by the use of rawhide plates, modified after Robinson's suggestion. In a recent paper I reported over fifty cases of such operations, and expressed a belief that after the technique described satisfactory results would be obtained. I recognize two serious difficulties in the making of anastomotic openings by any form of plate, viz., that of getting a sufficient opening without the plate becoming unwieldy, and in the second place the danger of septic infection of the peritoneum by the threads of the plate. The first objection I thought the easily manipulated rawhide plate—readily obtainable and promptly absorbed afterward—would overcome. The second I look upon as in a large measure theoretical, but perhaps unavoidable. A few months

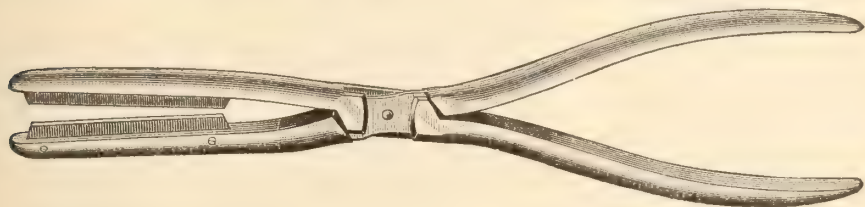
* Read before the Mitchell District (Ind.) Medical Society, July 13, 1893.

after the publication of this paper I read with great interest the report by Abbe (New York Medical Record, April 2, 1892,) of three successful cases by direct suture. I note his criticisms of mechanical devices and his suggestions. By *post-mortem* examination of patients dead some months, after successful anastomosis, is disclosed the contraction of the opening to about half its original size. Abbe declares it is not practicable to employ bone plates to make the opening long enough, and that other devices are unreliable; that the danger of leakage by the side of the plates is of moment, and that the time gained is too inconsiderable to weigh. Moreover, that the appearance and security of an anastomosis by direct suture is out of all comparison. This direct suture Abbe claims to have accomplished in twenty minutes. This method involves three rows of sutures around a four-inch incision. Each row would be some ten inches in length, equaling thirty inches of Lembert sutures under very difficult surroundings, together with ligating, irrigating, closing divided gut-ends, to say nothing of opening and closing the abdomen. Very few surgeons would offer to accomplish it in less than an hour, and only very considerable practice, added to special skill, could hope to do so in half that time. I could not be got to underestimate Dr. Abbe's skill, nor to undervalue the practical worth of his splendid paper, but rather to offer a comparison which indicates at what a disadvantage he has the great body of operators who may essay the plan. A very large proportion of such operations must be in a measure emergencies; time is not permitted always to get skilled experience, without which direct suture as herein suggested is hopeless. The great bulk of the profession is in earnest search for aid and security in this particular emergency, and must look for it outside the lines of special equipment and skill.

It is a most dangerous thing to underestimate the importance of the many little essentials in any capital surgery, easily as they may be executed by the experienced and skillful. Only in the hands of genius are the first surgical operations without mistake and awkwardness, and such mistakes and awkwardness mean almost certain death in operations in the abdominal cavity. Successful intestinal surgery is difficult of accomplishment always, not alone that wise and educated judgment is needed, but dexterity in a particular line only can hope to promptly accomplish the end. Unquestionably it is easier to make intestinal anastomosis by the plates, other things being equal. Whether these plates can be safely used to make the opening so long as Abbe declares

necessary in adults has not been tried. I think it would be very unsafe to attempt to approximate four inches of incision in this way. There would be great danger of leakage, and the bulk would be troublesome. It would be less dangerous to make the opening shorter and elliptical. I have never seen any sloughing in the gut-walls after an elliptical opening $\frac{1}{4}$ of an inch wide. Considerable portions are constantly removed after lacerated wounds of the intestines and stomach, and in operation for malignant growths of these viscera without sloughing. Still it is possible, and surely the limit of safety would be between $\frac{1}{4}$ and $\frac{1}{2}$ inch diameter of the ellipse. The length could be $1\frac{1}{2}$ to 2 inches without increasing the risk. The cicatricial contraction would be proportionately much less.

I am at present conducting some experiments to determine the amount of contraction in proportion to the diameter and length of the ellipse. For more than a year I have been endeavoring to perfect some instrument, after a suggestion by Dr. J. T. Blackburn, to simplify direct suture. The accompanying figure is the result.



It is only to be used after resection. The two blades of the clamp are long enough to admit of full 4 inches introduction into the bowel. The blades are $\frac{1}{2}$ inch wide, with each having a scissors-blade about $\frac{3}{8}$ inch high and $2\frac{1}{2}$ inches long, the outer end of the scissors reaching to $\frac{1}{2}$ inch of free end of clamp. The clamp locks like an obstetric forceps.

After the gut is exposed a strand of iodoform gauze is passed through the mesentery and constricts the intestines fully six inches from each point of intended resection. The mesentery is tied off over the portion to be resected with fine silk, in two-inch loops, cut close and dropped in the usual way. No V-shaped portion should be taken out, as such a step is a waste of time. When the resected portion is removed, the gut-ends may be washed out if desired. While the two ends of the divided intestine are held parallel, one blade is entered in each, allowing at least one inch of gut beyond the proposed anastomotic opening, to permit of

safe invagination of the ends. The clamp is tightened, and the two surfaces thus firmly held are rapidly stitched together by a continuous overhand Lembert suture of fine silk. Two rows of parallel sutures, as suggested by Abbe, may be used if desired, though it has seemed that one is enough in my few experiments. This work can be done far more rapidly and accurately than without the clamp. When the suturing is finished the clamp is farther tightened to cut well through the two approximated sides of the intestine. The scissors-action of the clamp, and the ten or fifteen minutes pressure during the suturing prevents any hemorrhage. The clamp is now partly opened, withdrawn, and the forefinger passed into the gut and the patency of the opening assured. The ends are now invaginated in the usual way. Severed grafts of omentum may be applied or not as seems indicated. There can be no question but that a fair test of the usefulness and safety of any method of intestinal surgery can not be got in experiments made on dogs, though much valuable information has been gained in this way.

With this clamp I have comfortably completed the stitching in eight minutes, and the technique of the work is easier than with the plates. I have used the clamp eight times on the living animal; the last six times with complete success. The mortality in the first two cases was due to faulty mechanism of the clamp, and consequent bruising of the mesentery of the bowel of a small animal. The anastomotic opening is seen after a few weeks' time as oval and uncontracted. There has never been any hemorrhage after the operation, and the shock to the animal is usually slight. It would be easy to make the scissors-blade longer if needful, but I can not think it necessary. The instrument is made by Tafel & Bro., of this city.

LOUISVILLE.

CICATRICAL STRICTURE OF PYLORUS; PYLOROPLASTY.*

BY A. M. CARTLEDGE, M. D.

Professor of Surgery in Louisville Medical College.

J. F., age thirty-eight years, native of Germany, presented himself to my notice September 7, 1893, with the following personal history:

He was a robust youth, and enjoyed perfect health until twenty-six years of age. At this time he observed, as he remembers, the rather sudden appearance of pain near the center of his stomach. This pain

*Read before the Louisville Medico-Chirurgical Society, September 22, 1893. For discussion see p. 308.

was intermittent in character, but at times very severe. The services of several physicians failed to relieve him. Some four years later, when about thirty years of age, he noticed the location of greatest pain and tenderness had shifted to a slightly lower plane, and more to the right, his description and location placing it about the liver notch. So far as he could remember, this change in the situation of pain was gradual.

The subsequent eight years of his history is one of varied suffering and symptoms. The intermission of the pain and a fixed and constant tenderness were always characteristic. During these years he noticed the passage *per rectum* of large quantities of a gritty substance resembling sand. Dejection of spirits and progressive emaciation were pronounced; no nausea or vomiting; appetite usually poor but variable; thinks he was slightly jaundiced two years ago. His physicians diagnosed "gall-stones." From January 1, 1892, to October of same year suffered pain almost constantly; was unable to attend to any business. At this time, October, 1892, was examined by several physicians with a view to operation. One of these, a surgeon, gave him great pain in manipulating the affected region. He was told to examine his stools and save any concretions that might pass. Two days after he found in a fecal evacuation a large-sized ordinary pin, much augmented in size by the adherence of deposit. He felt much relieved after the passage of the pin; the nagging and lancinating character of the pain left him, as did also a swelling that the physicians and he could distinctly feel before. His improvement, however, did not lead to health restoration. Pain and discomfort, together with some tenderness, remained, and have shown no disposition to lessen during the past year.

Present Status: A man fairly nourished, of good color, sad expression, tenderness over region of gall-bladder, and to the left. Deep palpation detects a slight enlargement in region of gall-bladder. Palpation and percussion reveal an enormous distension of stomach, extending from the fifth intercostal space to a line on a level with the umbilicus upon the left side. Heart's action unusually slow and steady, no murmur, pulse 60, no vertigo or other cerebral manifestations.

Diagnosis uncertain; certainly there was stenosis in the pyloric region, with every thing pointing to its being of cicatricial origin. There was a possible gall-bladder trouble in addition. With a statement of the facts to the patient, an exploratory operation was advised and accepted.

September 11th, assisted by Drs. Sherrill, Satterwhite, and Buren, the operation was performed. The usual incision for exposing the gall-

bladder was first made. This organ was found comfortably distended, but soft and pliable; palpation detected nothing but fluid in the cavity. To make doubly sure that this fluid was bile, and that no obstruction existed, the needle of a hypodermatic syringe was introduced and pure bile withdrawn.

A semicircular incision was now joined to the upper angle of the first cut, the convexity directed downward, and carried to about the center of the epigastric space. This incision severed the right rectus completely. The distended and dilated stomach soon presented, and was with difficulty kept back by flat sponges. A search was made for the pylorus, which was with some difficulty found. A marked thickening and induration was found, but very narrow, not more than one half inch in width. There seemed to be an unusual fixity of the pylorus, rendering its exposure difficult. The operation of pyloroplasty devised by Heineke, and later by Mikulicz, was performed.

This operation consists of a longitudinal section of the wall of the stomach and duodenum. This thoroughly severs all structures on a line with the pylorus, and permits also of reconstruction of the pylorus, so that it is impossible for the stricture to return when sutures are applied in a way we will mention later. It is certainly a very ingenious method. After an incision is made in the long axis of the duodenum and stomach, the center of the incision is drawn apart, making the transverse axis the long axis; then the sutures are applied, so that you really build up a new pylorus. This was practiced with considerable difficulty, owing to the unusual incision and deep-seated duodenum. The man did not have very thin abdominal walls, and I found it not a very easy matter to apply the sutures in this situation. The method of suturing was about the usual one; that is, a slight modification of the Czerny-Lembert suture.

Upon opening the stomach there was quite a little gush of mucus, nothing else, and there was a very notable collapse of the stomach from the gas that passed out. The stomach up to this time was enormous in size, as I have already stated, but could be easily compressed after the opening by the use of a flat sponge. After suturing the edges a strip of gauze was carried down to the point of suture and brought up and out at the middle of the wound. I did this, not that I feared so much the ability of my suture to hold, but because there had been an escape of mucus, and I feared infection of this region and preferred to practice drainage. There was considerable hemorrhage from the surrounding

structures in handling the stomach, and getting this out was attended with considerable difficulty, consequently I deemed it advisable to insert the gauze. The lower angle of the wound was drained in the same way. The progress of the case was not as uneventful as I would like. The man developed some fever; temperature 102° F. He has suffered considerable pain, necessitating the use of some morphia at various times; has taken probably about one grain and a half at different times since the operation. Recovery seems now assured. There is no evidence of leakage whatever. The patient was nourished exclusively by the rectum with peptonized milk for three days. The least possible amount of water was given by the stomach. He was then given beef tea, later peptonized milk by the mouth, and now for four days he has been taking strained soups, etc. As already stated, there has been no evidence of leakage up to the present time, and certainly there is no reason to expect there will be any now. There is still some little discharge at the point where the gauze points down to the pylorus. The lower drainage wound has entirely healed.

At the time this operation was first brought out it struck me as being one of great interest. First, the ingenuity of the operation, and second, the fact that physicians are very apt to overlook the very common occurrence of pyloric stenosis, the result of cicatricial contractions. There are a great many characteristic symptoms representing pyloric obstruction, which might easily be overlooked on the ground that we have heretofore called these cases "gastric catarrh," where we have atony of the gastric walls as a result of the catarrhal condition.

This operation, for the few times it has been performed, is certainly successful. Heretofore, as you are probably aware, the operation of Loreta was most common, that consisted of making an incision in the stomach near the pylorus, and if any stricture of the pylorus was located it was divulsed, and then the wound in the stomach was closed. This operation was found to be followed by about the same results as divulsion of stricture in other portions of the body; that is, there was a speedy return of the trouble; contraction of the divulsed structures soon took place, and the patient relapsed to his former condition. In the future, if we observe, I think we will find many more cases of pyloric stenosis than we have heretofore supposed.

In the case reported by me to-night the patient never had any nausea or vomiting; the trouble was cicatricial stenosis, as the operation proved beyond a doubt. Another interesting feature was the pin.

There can be no doubt but this pin was lodged in the stomach for the last eight years, although the patient has no recollection of ever swallowing it, and the last four years it has been near the pylorus. The changes in character and location of the pain, I take it, were due to the migration of this pin, and the continuance of distressing symptoms after passage of the pin *per rectum* was owing to cicatrization in the pyloric region causing stenosis in this locality. The patient has since made a very happy recovery.

LOUISVILLE.

SOME CLINICAL NOTES.

BY ALLEN H. KELCH, M.D.

The recent unusual prevalence of typhoid fever in our city and the attention its discussion attracted in the daily press renders the present an opportune moment for any one who thinks he has any thing of value to say concerning the subject to present it to the profession. Having received an abstract of a paper read by Dr. Wm. Waugh, of Philadelphia, before the State Medical Society of Pennsylvania, in which he reported over a hundred cases of typhoid fever treated without a single death, I felt highly constrained to adopt his method whenever an opportunity arose.

Dr. Waugh, after taking the view that most of the distressing manifestations of the disease (the excessive fever, the delirium, the tympanites and diarrhea) are due directly or indirectly to fermentation of the contents of the intestinal tract, generating irritative products to produce local mischief, and ptomaines which infect the general system, producing the high fever and delirium, adopted the method of intestinal antisepsis as the most rational means of avoiding the unpleasant features of the disease. It is not, however, so much his theory of *what* is to be sought by medication as it is his *how* that interests a practitioner. After discussing at more or less length the various disinfectants, he chose the sulpho-carbolate of zinc as the most suitable, not because of its germicidal properties, but because of its anti-fermentive and sterilizing powers.

In the course of the prevalence of the disease this spring it fell to my lot to treat several cases, and I eagerly embraced the opportunity thus presented to test the theory and the practice. The subjoined

report of three cases might be amplified, but they are typical of the results obtained in all.

CASE 1. J. S., eight years old, after a period of five or six days of *malaise*, under expectant treatment developed the characteristic temperature range of typhoid, the stools becoming at once alarmingly frequent, with continued colicky pains and gurgling. Vigilance rather than dullness marked his mental state. He bore the evidences of the onset of a rather severe typhoid. At noon of the second day, his temperature being 103° , with the prospect of a further rise, he was ordered *zinci sulpho-carbolate*, iv oz.; *elixir calisaya* and *phosphates*, iss drs.; M. S: a teaspoonful every four hours. The following morning his temperature was 99.5° , in the evening 101° , and he had two actions from the bowels. From this date to the end of his disease on the eighteenth day his temperature did not vary one half a degree from the last record above given. His stools became inodorous the day following the exhibition of the zinc, and at the end of three days had become normal in consistence and number. A few rose spots appeared, tympanites was little more than perceptible; he had slight mental aberration, but for only a short period, on two separate days. He had no other medicines.

CASE 2. W. G., twenty-four years old, took his bed on Thursday evening; was first seen on the following Monday; had been to stool fifteen or twenty times on Sunday and eight or ten times this day; constant nausea and some vomiting; griping pains severe. He was consecutively cold, hot, and perspiring. No mental hebetude was present. He was given *quinia sulph.* xv grs., *morph. sulph.* $\frac{1}{4}$ gr., at once, the morphine to be repeated every three hours if necessary to secure sound sleep. At 10 A. M. the next day his temperature was 102° . He had slept soundly, and his bowels had moved once. He was ordered *elixir calisaya* and *phosphates* iv oz.; S: a teaspoonful every four hours. At 9 P. M. his temperature was 103.5° . His bowels had moved twice, and he was suffering from colic. He was ordered *morph. sulph.* $\frac{1}{4}$ gr., *zinci sulpho-carbolate*, iiss grs.; S: at once. At 8 A.M. his temperature was 100° . He had slept well. No action; no colic. The morphia was withdrawn, but the zinc and *elixir of calisaya* continued. There was no occasion for any change in his medicines for two weeks, as his temperature never after rose above 100.5° in the evening, and was nearly always 99° in the morning, with one action of normal consistence daily without pain. Rose spots appeared, tympanites was perceptible, and gurgling easily elicited on pressure. On the fourteenth day the patient

could scarcely be prevailed upon to keep his bed, and the dose of zinc was reduced to one grain every four hours. The day following he had three actions, and his evening temperature arose to 103.5° . The zinc was immediately increased to five grains for the next three doses, but the day following was an uncomfortable one for him. From that time, however, to the twenty-fifth day, when the crisis occurred, he followed the even tenor of his way, and beyond the two days mentioned he hardly regarded himself as sick, rather a prisoner.

CASE 3. W. K. T., thirty-four years old, took to bed on Friday. First seen Sunday evening. His attack was ushered in by a severe diarrhea and the symptoms of a violent acute coryza. The following day he presented the characteristic temperature range, 101° in the morning; 103° in the evening. Pills of sulpho-carbolate of zinc, each two and a half grains, were ordered every four hours. The diarrhea was checked and constipation supervened; this was permitted to be relieved by a saline laxative on the fifth day—permitted, but not advised—in order to quiet the apprehension of relatives who feared “something might happen.” Rose spots appeared promptly, tympanites was perceptible, the temperature ranged from 99° to 100.5° until the seventeenth day, when crisis occurred, and a few days later the patient sat up and promptly recovered. This man did not feel himself sufficiently ill to give up the use of his tobacco, which he both chewed and smoked throughout his entire confinement to bed.

Eight other cases I attended in one house, members of two families; but to detail their cases would be but a tiresome repetition of what has already been said. All of them recovered, after an illness of seventeen to twenty-six days, without a single distressing manifestation of sickness.

With results so uniform, and from a treatment so consistent with our knowledge of the nature of the disease, it would seem we can truly hail the day of scientific results in this one of the most dreaded foes we have to encounter. With such results we can hope, at least, that the clinical history of typhoid fever, modified by appropriate intestinal antiseptics, will in the future contain less of the harrowing descriptions of delirium, excessive fever, diarrhea, tympanites, hemorrhage, perforation, and cardiac failure so prominent in the treatises we have been accustomed heretofore to read.

On clearly analogical grounds I have had also some remarkably rapid and satisfactory results from the use of the sulpho-carbolate of

zinc in the summer diarrheas that have been and still are so prevalent among us. Its action in allaying the pain of hyper-peristalsis and distension is almost as rapid and very much more permanent and satisfactory than that secured by morphine, and the most severe tenesmus in more than one instance has subsided coincident with its action.

LOUISVILLE.

"RUNNING AMOCK."

BY EWING MARSHALL, M. D.

Physician to Home of the Friendless, Physician in Charge P. E. Orphan Asylum, Consulting Surgeon to Louisville City Hospital.

In the London Lancet of September 16, 1893, we find an annotation with the title "Running Amock." A *resumé* may be of interest in connection with a personal experience calling for thoughtful consideration:

"The curious psychosis which is prevalent in the East, but more especially in the Malay peninsula, and which is popularly known as 'running amock,' is described more or less minutely and carefully by various observers, but with regard to the essential features of the seizure there is little difference of opinion. The active agent, armed usually with some more or less deadly weapon, starts his wild career, as a rule, in some public road or thoroughfare, running along stabbing or otherwise maiming all who come across his path, and he pursues his way until he is brought to bay in a more or less forcible manner.

"This violent outbreak is usually preceded by a period of depression, intensified, according to some, by a willful brooding over wrongs, real or imaginary—'nursing his wrath to keep it warm,' and it is with regard to this period of depression and morbid introspection that we have ventured to designate the condition as a psychosis.

"Such manifestations of homicidal mania, however, are not, unfortunately, confined to what are usually known as the inferior races.

"Post-epileptic mania, with homicidal impulses, is a condition with which our criminal courts are familiar enough, although in the opinion of many the slighter forms of it, and especially the curious but most dangerous automatism which follows slight epileptic fits, are not sufficiently taken into account in these places.

"The same may be said of the form of epilepsy known as 'procur-sine,' in which the patient commences to run without apparent object.

This condition may either precede or follow an epileptic attack, but its chief danger is to the patient. There are, however, other conditions even more closely resembling the 'amock' of the Malays, which are undoubtedly the result of a disturbed psychical condition; and our daily contemporaries recently furnished intelligence of an example of this of a very grave and unfortunately most tragic character. A man of Dundee, who had been much abroad and was the subject of ague, after a course of conduct spreading apparently over several weeks—sufficiently curious, to say the least of it, to have attracted the attention of the authorities—deliberately shot at and wounded two women, firing several shots to effect his purpose. He then retired to the attic where he lived, defying any one to enter, and he was not secured before he had inflicted serious, and in some cases, fatal injuries on the police officers and others who tried to secure his capture. Such a deplorable occurrence as this is all the more to be regretted because of the fact that for some time the man's behavior had been the source of much annoyance, not to say anxiety, to his neighbors; and if the account which has appeared in the papers is an accurate one, it seems strange that steps were not taken to have him at least carefully observed before his mania had led to the serious results to which we have just referred. Such a 'running amock' should scarcely be possible amid all the safeguards with which we are surrounded. No doubt it would have been shorn of many of its terrors if even slight difficulties had been placed in the way of his purchasing a pistol."

This account brings forcibly before me a recent experience, and the question, what should be done under the circumstances?

I was called hurriedly to a house where just a month previous I had delivered a young woman of a baby. The couple had been married just ten months when the baby was born, and the whole connection was rejoiced by its coming.

In answering my summons I supposed it was some simple ailment of the child, but when I reached the house I found the wildest excitement. When I reached the bed-room the young mother was crying and hysterically wringing her hands. Upon inquiry, they informed me the cause of her condition was her husband, who had demanded that she leave Louisville at once. They told me the husband was drunk and was threatening all kinds of things unless his wife acceded to his wishes. Some male relatives, who had been summoned to act as a body-guard, urged that the man be arrested. I suggested temporizing, and

said I would attempt the part of mediator. When I found him, he was lying in a corner of the front-yard, quite drunk, yet sufficiently at himself to talk in a way that convinced me it was as much mental aberration as drunkenness that was causing his wild actions. He insisted he would never enter the house until his wife agreed to go away with him. When I returned to the wife and asked how long he had been in this condition (mental aberration), she said it began sometime before the baby was born. He imagined himself rich, and took her little savings and wasted them by putting them up to cover an option on a piece of ground, the first payment on which, when the time came, he could not meet. And since the arrival of the baby he had acted very badly, insisting on bringing the little thing to the dinner-table and giving it all manner of things, pie, watermelon, and any thing that happened to be on the table. He imagined himself not properly considered, first in one church and then in another. These and other things were mentioned and confirmed me in the opinion that I had formed of his mental condition by my talk with him; therefore I then urged his wife to have him arrested and immediately institute proceedings to obtain a divorce. She would not consent, though urged by all her relations who were crowding the house, to follow my advice. After repeatedly reasoning with her, and finding it of no avail, I left. What was the outcome I have not heard.

Now, what should be done under the circumstances? It was my belief that the father of that child was in a condition bordering on homicidal mania. Continuing in that condition much longer he might have started "running amock." The wife would not agree to have an officer called in her name. None of the relatives would take the responsibility. Was it the place of the attending physician to notify an officer and have him put under restraint, at least until his spree was over? And last, should not a bar-tender, recognizing that a man is on a protracted spree, be punished for continuing to sell him liquor?

LOUISVILLE.

A SUICIDAL EPIDEMIC.—An unusually large number of suicides has been reported this summer, both in this country and in Europe. London, Paris, and Hungary are especially afflicted. Many of the cases have had no discoverable reasons for their occurrence. The usual conditions of long-continued dark, wet weather, said to cause an increase of suicides, have certainly not been present this year.

Reports of Societies.

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.*

Stated Meeting, September 22, 1893, Dr. T. L. McDermott, President, in the chair.

Dr. W. L. Rodman (Case of Double Hydrocele): This gentleman, forty years of age, comes from the southern part of the State, and presents a condition that, as far as my experience is concerned, is rather uncommon, especially in a man of this age. Four weeks ago he noticed a swelling in the right side of the scrotum, and now you will observe the enlargement extends to both sides, very marked in the right but not so marked in the left. I have made diagnosis of double hydrocele. The right side presents the typical appearance and shape of a hydrocele, very tense, so much so that fluctuation is elicited with a great deal of difficulty. The amount of fluid in the left side is not so great, yet there is some. The patient thinks that the tumor of the left side varies considerably in its size and position. I made a very careful examination with the patient in the recumbent position, and was unable to produce any appreciable diminution in the size of the tumor by manipulation. Another interesting feature is that the trouble began only four weeks ago; I think it is unusual to find a hydrocele which has attained such a size as this has done in the right side in so short a time. There is no history of traumatism or other assignable cause for the trouble.

DISCUSSION.

Dr. C. Skinner: What operation do you propose to do in the case?

Dr. Rodman: I shall perform the same operation that I usually do in cases of this character, that is, inject carbolic acid.

Dr. A. M. Cartledge: This strikes me as it has Dr. Rodman, who presented it, as being a rather unusual case. I have seen several cases of double hydrocele, but they have usually been in older men and degenerations from epididymitis, etc., but the history of this case dating back only four weeks, attaining the size it has in that length of time, and the peculiar feeling of the left side, which is not so developed, I think throws at least a suggestion upon the case. The cord structures

*Stenographically reported by C. C. Mapes.

of the left side seem to be very much enlarged, the vas and blood-vessels also, and I take it that we have in this case a purely symptomatic hydrocele, and there are serious changes going on within the structures of the scrotum. Of course very little can be told in regard to the right side until the water is drawn off. The left side presents several suggestive features. I think, just a rather uncertain diagnosis of the case, that it is probably an acute tubercular lesion. From the feeling of the left side it would indicate extensive infiltration of the cord structures with tubercle, and I believe the doctor will find the same condition existing on the right side after withdrawing the water. In my judgment the whole trouble is the result of changes purely in the cord structures, affecting the circulation.

Dr. W. O. Roberts: I have very little to add to what Dr. Cartledge has already stated. As the trouble has existed for so short a time, I asked the question when he was examining the tumor whether there was any hardness about the cord or epididymis. I think, just as he has stated, that it is possibly symptomatic. Of course no accurate diagnosis can be made until the fluid is drawn off, when the structures can be thoroughly examined. It has come on too rapidly to be simply a pure hydrocele.

Dr. W. C. Dugan (visiting): I take it that this case is rather peculiar, inasmuch as both sides are involved. But I have seen in the last two years two cases of acute hydrocele in old men that came on in a few hours. One of them I remember developed in three or four hours. The patient was thought to have a strangulated hernia. The tumor on one side was as large as a child's head, containing over a quart of very clear fluid. Believing the testicle was diseased, I removed it and the cord very high up. There was no evidence of any pathological lesion at all in that case revealed on the most careful examination after it was removed. Of course it was much atrophied, as would be expected in very old men. The cause of such trouble I am unable to explain, but that such conditions are met with is known to every practical surgeon.

Dr. Rodman: The left side (patient exhibited by me to-night), as Drs. Cartledge and Roberts state, presents an unusual appearance, and it led me to make a very careful examination of the case. The right side seems to be a typical hydrocele. I admit that the course of this trouble is rather unusual, and yet it is a fact, as Dr. Dugan says, that we do have acute and chronic hydroceles. While it will not be often found that a case of hydrocele will attain such a volume in four weeks,

still they do run such a rapid course at times. I am inclined to think this is simply a double hydrocele without any tuberculous lesion at all. The man's age is rather against tubercular change in this region. Young subjects are more apt to present tubercular epididymitis than men forty years of age, and while I admit that the condition is a little unusual, at the same time I think that this is simply a double hydrocele of the acute variety. I have seen hydrocele appear and disappear inside of a week or ten days; they sometimes come on very rapidly. Of course hydroceles which pursue this course are as a rule very small and absorption is rapid. I do not believe there is any tuberculous change in this case, but I shall make a very careful examination to-morrow when I operate on him, and report at the next meeting. One point I neglected to mention in giving the history of the case, and that is the man has never had any pain in the testes and no fever.

Dr. J. L. Howard (Suprapubic Cystotomy for Removal of Two Stones from Bladder): I present here two stones removed from the bladder of a man seventy-three years of age by the suprapubic operation. The only interesting feature about the case is the character of the stones. I had one of them cut in two. It shows the uric acid nucleus very beautifully, one layer of uric acid then a layer of lime.

DISCUSSION.

Dr. Roberts: Nearly always in old men the stone is phosphatic in character. I removed three stones from the bladder of a man sixty-seven years of age, and two of them were decidedly phosphatic, the third mixed. I would like to ask Dr. Howard if his patient had any difficulty in passing water from prostatic trouble.

Dr. Howard: At the time of the operation he had no prostatic trouble whatever; however, he had a prostatic enlargement secondary to the operation. About a week afterward, in attempting to close the external wound by tying a catheter in the urethra, I found it almost impossible to insert a straight catheter, but finally succeeded in passing a prostatic catheter. The enlargement subsided in about ten days. The drainage employed was gauze, the abdominal wound united readily, and the patient has had no trouble in passing water for the last three weeks. The operation was performed six weeks ago. He passes water now only about every three or four hours, while heretofore it was every few minutes.

Dr. Rodman: I assisted Dr. Howard in the operation referred to, and saw the patient about a month thereafter, and he was entirely relieved of all symptoms. I have never seen a case of lithotomy which was followed by better results.

Dr. Roberts: Do you know whether this man had any history of renal colic at any time?

Dr. Howard: No such history could be elicited.

Dr. Roberts (Fatty Tumor): I have a specimen here which is not much in itself, but is of interest because of the location in which it was found. The patient was a child three years old. This tumor was first noticed two years ago, that is when the child was one year old, located on the palmar surface of the hand between the fourth and fifth metacarpal bones near the phalangeal articulation. I saw it for the first time about a month ago. It was then of considerable size and kept the fourth and fifth fingers widely separated by its pressure. Upon examination I was led to believe from the location of the growth and from the hardness of it that it was an enchondroma, but when it was cut down upon, much to my surprise, I found it to be simply a fatty tumor.

DISCUSSION.

Dr. Rodman: This is one of the regions of fatty tumors, but enchondromas are much more common. The fleshy part of the palm is the only portion of the hand where lipomas are found.

Dr. Roberts: I removed one some time ago, three times as large, from the ischio-rectal fossa of a child three years of age.

Dr. Rodman (Irreducible Hernia—Operation; Abscess of the Omental Stump—Recovery): This specimen was removed from a gentleman who was brought to me from Indiana, thirty-three years of age, who had had a hernia upon the right side for several years. It had been reducible until a few years before he was brought to me. It had become irreducible, the patient was having considerable pain, and while the physician in attendance did not think the hernia was strangulated, yet he believed it was a favorable case for operation. It was a very large epiplocele, the largest I think that I have ever seen. The quantity of omentum was so large that I divided it into four equal sections and ligated each with catgut. The operation was done after the method of Kocher, of Berne. I have done quite a number of similar operations

in the last year, and all of them have done absolutely well, except this one. The man is now perfectly well; did not have a single bad symptom until the thirteenth day; then I noticed a swelling in the right iliac region, and I at once thought there was some trouble with the omental stump. A short time before performing this operation I had read an article by W. T. Bull, of New York, in the *Annals of Surgery*, in which he calls attention to this complication. So far as I know he is the only one that has done so. He reported two or three cases, one in which an abscess of the omental stump occurred as late as six months after the original operation. This is what occurred in the case reported by me to-night. After the tumor attained the size of a doubled fist it broke, and of course since then he has had entire relief, there has not been a bad symptom. It is the first time I have seen a complication of this kind, and would have been at a loss to understand it had I not read Bull's article a few weeks before. The stump was ligated with catgut and the sac was ligated with silk pulled well out so as not to leave any infundibulum there to induce further return of the hernia. In none of the cases upon which I have operated has there been any return of the hernia. The first operation I did according to this method was eighteen months ago. I have had no death.

DISCUSSION.

Dr. Cartledge: I was especially interested in the report of cases by Bull, referred to by Dr. Rodman, concerning trouble with the omental stump, as I had recently had two. One was a very large epiplocele in an old woman; the whole mass was carefully ligated away, and returned. Later she developed (the hernia was on the right side) quite an induration high up in the abdomen which was very sore and tender, and, like Dr. Rodman, I was at a loss for a while to know its true nature. Just about that time Bull's article appeared, and I at once recognized that the trouble was in the omental stump. The patient had several attacks of circumscribed peritonitis, which finally subsided, and she made a good recovery.

The other case was one following ventral hernia, that occurred after laparotomy had been performed twice. The third time it was followed by a ventral hernia, and upon opening up the structures it was found that the omentum was adherent in the left iliac fossa, having become very tense and thick. This was stripped up, the lower attachment tied off with silk ligature and the operation completed. Subsequently this

woman developed a hard induration in the left side of the abdomen which finally led to another exploration. I thought I could demonstrate the existence of pus. There was some little elevation of temperature, going as high as 101° F. After several months I made an incision, and we were very much puzzled because of the extent of the induration and its location, it being so low down. After searching around thoroughly and discovering nothing, I simply closed the wound; however, I inserted a small gauze drain at the bottom. This remained for some days and was then removed. She seemed somewhat better and went home. Every night the opening where the gauze drain came out would fill with serum and discharge. This kept up for probably five or six weeks, and finally the old silk ligature that was around the omentum came away. Since that time she has been perfectly well, showing that the irritation was really due to the silk ligature around the omental stump.

I believe in these cases catgut instead of silk should be used as the material for ligature, and in tying off large masses of omentum it should be divided into sections. I can look back now and see other cases where the omental stump has probably been the cause of trouble, but these two cases occurred just prior to the publication of Bull's report of three cases which terminated in resolution and one death, making a total of four cases. One of mine terminated in resolution after passage of the silk ligature; the other terminated in resolution after rest, warm applications, etc.

Dr. Dugan (Bassini's Operation for Hernia—and Discussion of Case reported by Dr. Howard): The foregoing remarks recall to mind a case I operated upon at the Children's Hospital last spring. We did Bassini's operation for hernia, and the child left feeling perfectly well and without a truss. I received a letter from him last week, in which he said that he got along all right until a short time ago: while swimming or diving he fell on his abdomen (at least he attributed the trouble to this fall) and shortly afterward he had a little abscess and the omental ligature came away. It is simply another case of trouble from the omental ligature, and I wish to record it as such.

Referring to the case reported by Dr. Howard and specimens exhibited, I did a median operation recently upon a man in Indiana for multiple calculi, removing fifteen or twenty small stones. Their character was mixed oxalic and uric acid, being very hard. The patient also had

an enlarged prostate; the central lobe was very much enlarged and attached to the bladder all over its upper surface, so that it could not be gotten around till the adhesion was broken up. I worked it up and passed a pair of curved forceps over it, and, letting the forceps drop into the bladder, picked out fifteen or twenty stones. Then I thought we had gotten them all away, but, introducing a searcher, felt a stone in the left side near the left ureter. I made every endeavor to remove it, but failing, then resorted to the suprapubic operation. The bladder was then searched thoroughly, but the stone could not be found. I am convinced that when the stone was detected with the searcher it was in the mouth of the ureter, coming down from the kidney, and in the attempt to remove it was pushed back in the ureter, which accounts for our inability to find it after opening the bladder. This patient got along nicely, made several reports that he was doing well and was going to recover. He was in the hands of a physician about ten miles distant, who left the treatment of the case largely to the family. At about the end of the second week after the operation the man developed lockjaw and died. I simply mention this to emphasize the danger of leaving patients to be treated by the family, who can not take proper precautions against sepsis and infection. I am quite sure this patient was infected in that way, and believe if he had been in a hospital it would not have occurred. His physician was an able practitioner, but of course, living so far away, it is impossible to give such cases personal attention each day.

The essay was read by Dr. Cartledge; subject, Cicatricial Stricture of Pylorus. [See page 292.]

DISCUSSION.

Dr. Roberts: I simply wish to congratulate Dr. Cartledge on the excellent result. I have under observation now a young woman who a week ago swallowed a pin, and she has been complaining ever since of pain in the region of the pylorus, and there has been a doubt in my mind as to whether or not an operation would become necessary for its removal. There is considerable tenderness in this locality, but there has as yet been no fever, no vomiting, and apparently no difficulty in the discharge of food from the stomach. I shall watch the case with great interest, and in the event operation becomes necessary shall adopt the method described by Dr. Cartledge.

Dr. Rodman: I have had no personal experience in cases of the character under discussion. I rather think, as Dr. Cartledge says, that possibly these pathological conditions are more common than generally supposed. It is remarkable how pins and substances of like nature can be retained in the alimentary canal and tissues surrounding it for so long a time. I remember, while serving as physician in the Kentucky penitentiary, to have opened an abscess in the abdomen of a convict, and out of this abscess I removed three headless pins. The man had been a painter here in Louisville and had been in the penitentiary for about twenty years at the time. He told me that while following his vocation here he was in the habit of taking these pins with the heads cut off in his mouth and frequently swallowed them. As he had swallowed no pins since he had been in prison it is evident that those taken from the abscess had been in the body for over twenty years.

Dr. J. A. Larrabee: While the subject of "pins" is under discussion I want to mention one case which may be of some interest. The patient, a child three and a half years of age, complained of rectal trouble, and from which she could get no relief. An examination revealed a safety pin pinned into the lining of the rectum. There was no history or knowledge on part of the child or mother of a pin having been swallowed, and how it got there is a mystery.

Dr. L. S. McMurtry (visiting): The case reported by Dr. Cartledge seems to me to be very unique. I think it demonstrates that surgery of the stomach is destined in a very short time to take a place with surgery of other parts of the alimentary canal that will make it thoroughly practicable. The trouble has been that operations of this class heretofore have only been done for malignant disease and in cases where the patient was in a dying condition, which is not a fair test for any operation; but it seems that this is the crucial test of nearly all new operative procedures, especially in abdominal work. I think the case Dr. Cartledge has reported, which resulted so happily, should encourage more frequent operative interference in troubles of this kind. Take, for instance, the case of Dr. Bernays, a celebrated case which doubtless all of the Fellows of the Society remember, where a juggler in a theater was in the habit of performing the trick of almost swallowing a case-knife, allowing it to pass down the esophagus. One evening it slipped from his fingers and passed down into the stomach, and an operation was performed for its removal within a couple of hours. The stomach was opened and the knife taken out, the wound was carefully closed in

about the manner Dr. Cartledge has described, and the man made an uninterrupted recovery. There we have something like a fair test of what can be done in skilled hands in opening the stomach. The case reported by Dr. Cartledge is just in the same line, where the patient did not have malignant disease but did have a disease which certainly justified heroic steps in order to bring about a cure.

There is only one point upon which I could criticise Dr. Cartledge's technique, and I do not know that I have the right to do that, but think it would have been better without gauze drainage. I believe that to have inserted a drainage-tube, which could have been emptied every fifteen or twenty minutes and the tube removed at the end of twenty-four hours, would have been preferable. I do not think, in any case where we want to drain away blood or mucus, that the gauze drain is advisable. If you will notice a capillary drain, it drains almost entirely serum. The lymph becomes entangled in its meshes very rapidly, which makes it difficult to remove it in twenty-four or forty-eight hours. When it is necessary to drain at all it can better be accomplished by an open drain and suction than with gauze. I believe that the patient would have recovered without drainage, but in the choice of drain I would have been disposed to select a tube.

Dr. Cartledge: This operation, as I have said, originated with the two men, Heineke and Mikulicz, from the fact that Heineke described the operation, and eleven months afterward Mikulicz performed it with entire ignorance that it had ever been devised and described by Heineke. For this reason the operation was named after both these gentlemen. They advise that the incision shall be through the pylorus and then extend one inch up into the anterior wall of the stomach and one inch into the wall of the duodenum. In doing the operation it struck me that this was entirely too much, and I made up my mind that a shorter incision would probably answer. I do not believe my incision was over one and one fourth to one and one half inches in length. The stricture was not very wide, but it was very hard and thick. Another thing I discovered was the remarkable friability of the structures; they had to be handled with great care. After making an incision I passed my finger partly down to prove what the condition was, and found that the tissues were quite soft, and with this slight traction were liable to be torn. It also had to be sutured with the greatest care, and I found that I was disappointed in regard to the ease with which the operation could be performed. I found that, when you put it to the test of practice,

suturing up the duodenum is not a very easy thing. I congratulate myself that this operation was performed and the patient off the table with all dressings applied in fifty-nine minutes. However, this I believe to be a longer time than the operation should require. Of course we had spent some time in examining the gall-bladder, inspecting the fluid withdrawn, etc., and I think if I were to proceed directly with the operation it could be accomplished in from twenty-five to thirty minutes. The operator has to work through a small aperture in placing his sutures, and it is altogether quite a difficult procedure. I do not see any necessity for making the incision in most cases longer than one and one half inches. The operation has been performed but a few times in this country.

Dr. Roberts (Operation for Tumor of Prostate Gland): Under the head of continued reports of old cases I desire to mention one case that I reported to this Society some time ago. The patient was a man from whom I had removed a tumor of the prostate gland that obstructed the passage of urine. This man had not passed any urine voluntarily for a year. The patient was brought to me by Dr. E. R. Palmer, and referred to him from near Winchester, Ky. I removed the tumor, and soon after that he went home. At the time I reported the case I had a letter from a son of the patient, who is a physician, stating that his father was able to pass water naturally. Since then I have received another letter, within the last three weeks, in which he says there is no trouble whatever in emptying the bladder, that the patient has made a good recovery.

Dr. Larrabee (Case of Simple Meningitis): I have recently had some cases that have been interesting to me. One in which I was especially interested was a case of simple meningitis in a child about a year and three months old. I was called to see this child by Dr. Freeman, of Beard Station, Ky. The case was interesting because of the fact that we see so few cases of simple meningitis in comparison with those of tubercular origin. Simple meningitis is oftener, in my judgment, due to injury or to disease of the middle ear. Inquiry in regard to this case showed that three weeks previous to any symptoms the child had been thrown from a buggy, receiving a blow on the head. An examination showed that the skin was adherent to the pericranium at one point. At the time the history of the case was that the child turned perfectly blue, then white, then vomited several times, but the next morn-

ing felt perfectly well, and no other symptoms developed until the end of two and one half weeks, at which time unmistakable symptoms of meningitis developed. To-night the child is out of danger, by simply rest and treatment with bromide and a little calomel. The length of time between the fall and development of the pathognomonic symptoms of inflammation of the meninges seems a little singular.

(Hemiplegia following Injury.) No. 2. Another case I would like to report and have some light thrown upon, where a gentleman was relieved of a very serious condition, is as follows: Patient, male, fifty-five or fifty-six years of age, a well-to-do, well-kept man, in the upper walks of life, and one who has attended to himself properly; has never had an illness; is of considerable size, rather of the apoplectic build, without the florid countenance, however. Three nights ago this gentleman fell to the floor with paralysis, as was reported over the telephone. I saw the patient immediately afterward and found him hemiplegic; found no sensation whatever, no response to a blow on the foot or a pin in the hand; good intelligence, however. From this state of affairs my prognosis was very serious, and I gave very little encouragement as to the outcome of the case, thinking, of course, that the condition then existing was going to remain. I immediately administered ten grains of calomel and ten grains of jalap. This had a decided effect, and I found the next morning that he had hyper-catharsis. I saw him at 2 o'clock that day, at which time he could move his foot in bed. I used a pin on his hand and found that he had a little sensation; he said he knew I was doing something to him. Yesterday morning he was able to move both his hand and foot; to-night he can move them more freely but says he does not feel quite natural. Now the question is, what was it? It certainly could not have been infarction of the vessels, and I am rather puzzled.

Subsequent to the meeting I learned that this patient had sustained an injury in climbing a fence—a strain of both arm and leg—and that was only two days before the paralysis.

Dr. T. H. Stucky: A child twenty-three months old died under my care about five weeks ago, and from the symptoms present I can see no reason why he died. I want to report the case to show what marked pathological changes had taken place compared with the symptoms during life. Five weeks ago I was sent for on Tuesday morning to see this child; the mother said that during the night the baby had commenced vomiting and had a little diarrhea; tongue was flabby, temper-

ature 100° F. I gave it one-eighth-grain dose of calomel and one grain of lactopeptine every hour until the character of the stools changed. The next morning I again saw the patient and found the temperature 101° F. I gave it one grain of tannate quinine every three hours. That afternoon I visited the patient and found temperature 102½° F; treatment continued. On my visit the next morning I found that the temperature was about normal, there was apparently no abdominal tenderness, limbs not flexed, and the child had every appearance of being on the high road to recovery. I told the family that I would see it again the next day. The next day about 2 o'clock I found that the child had every appearance of being in collapse; temperature 104°; marked opisthotonos, and died in about sixteen hours. I will quote the result of the autopsy as made by Dr. Louis Frank:

. . . Body of child well nourished, male. Head: Duramater adherent to skull; at vertex these adhesions are so dense that it is impossible to separate the dura from the bone; the pia is slightly distended, a clear fluid escaping when pia is cut through. Along the vertex there is some cloudiness, milky appearance along the larger vessels, and in this a few whitish tubercles are found scattered about near the fissure of Sylvius and at vertex. The layers in the Sylvian fissure are adherent. Lateral ventricles contain about one half ounce fluid, clear. Ependyma somewhat cloudy. Abdomen distended, median section, pus and fibrinous flakes appear. Cavity contains pus about eight or ten ounces, which is mostly however in the pelvis. Intestines agglutinated, but the coils can be separated from one another. The vermiform is found passing down into the pelvis and is held there by adhesions to the sigmoid and rectum. The sigmoid lies somewhat over it. After separating carefully the rather firm adhesions the appendix is found to be about three inches long with a mesentery to its proximal one half. The distal end appears white and is embedded in adhesions (fibrine). The appendix after ligation is taken out and opened. It presents a small perforation at its extremity; contains no feces, seeds, or other foreign body: is filled with a thick, mucus-like substance. . . .

In connection with this statement of result of autopsy I want to state that at no time during the child's sickness was there any abdominal distension. The bowels seem to have been restored to natural condition; there was no history of chill and no explanation of the cerebral condition. Careful inquiry reveals no history of tubercular trouble in the family on either side and no history of specific trouble on the father's side; that the only injury the child had ever sustained was received about eight months ago, when he fell out of a chair on the

top of his head. They did not think it necessary to call a physician, as they thought he was all right. At 9 o'clock in the morning, or three hours before I was called hurriedly by telephone to see this child, he was sitting on the floor playing with some blocks. I met his father that morning and asked him how the little boy was, and he replied that he was all right. That night he died. The case is of interest to me from the simple fact that the symptoms existing were out of all proportion to the revelations made at the autopsy.

DISCUSSION.

Dr. Larrabee: The case is certainly one of extreme interest and one upon which very little light can be thrown, especially as there is no history of either a specific or tuberculous nature. If the injury had any thing to do with the adhesion of the dura mater and condition of the brain found, then, according to all pathology, the child should have had epilepsy or seizures of some kind. In regard to the pus found in the abdomen, while peritonitis is not often overlooked or mistaken in the adult, I have seen children have peritonitis without diagnosis very many times, have had it occur in my own practice, where symptoms were not present to such an extent as to attract attention or sufficiently marked to be separable from ordinary colic or gastric attacks and diseases of a milder character; but from the fact that there was a perforated appendix it would seem that this mischief had been going on for a considerable time; this is also evident from the mal-position of the appendix and agglutination of the intestine. It is a very anomalous case and one on which it would be very difficult to throw any light.

Dr. J. M. Ray (Papilloma of Larynx): I have had under observation for several days a case of papilloma of the larynx. A woman thirty-eight years of age consulted me for loss of voice with this history: Three years ago she suffered in a similar way, having a cough and loss of voice; with an effort she could make a tone loud enough to be heard, but it was only with quite an effort that she was able to do so. One day she was seized with a severe attack of coughing and spit up quite a lump, which on investigation proved to be a lump of flesh as large as a bean. Immediately after that she could talk with ease and had no further trouble until recently when she began to get hoarse again, with considerable cough. This increased until she decided to consult a specialist. When I saw her a week ago she could talk in an ordinary tone

but with a little huskiness, and she said she could not call the children about the house and had not been able to do so for several weeks. Upon looking into her throat I found in the larynx, occupying the inter-arytenoid space, a papilloma probably about the size of a bean, and with a broad base. I told her it would likely have to be removed. To-day I clipped off a piece of it, but did not succeed in removing it all as the throat was rather sensitive, and I decided to make another attempt later. The interesting feature of the case is that the patient had the same trouble three years ago, the growth evidently becoming pedunculated, and in coughing it was broken loose and spit up. Cases of this kind occasionally occur in children, where papilloma of the larynx becomes detached or disappears, but this is the first case I have ever seen in adult life.

DISCUSSION.

Dr. Palmer: Are there any reasonable grounds for suspecting syphilis in the case?

Dr. Ray: There is no such history, no ulceration or other evidence of syphilis. The larynx is perfectly free from inflammation. The location of the growth in the inter-arytenoid space probably accounts for the excessive cough.

H. A. COTTELL, M. D., *Secretary.*

PHENATES OF BISMUTH.—Jasenski (*Arch. des Sciences Biologiques de St. Petersbourg*, T. ii, No. 2, 1893,) finds that phenol-bismuth, cresol-bismuth, and β naphthol-bismuth, when introduced into the stomach, become decomposed there into their components under the influence of the gastric juice. A portion, however, escapes decomposition here and passes on into the intestine, where it is finally split up. The phenol and cresol, separated from the bismuth, are entirely absorbed, eliminated in the urine as sulpho-conjugate acids, or combined with glycuronic acid. The β naphthol is only partly eliminated in this manner, the remainder passing unchanged through the whole length of the digestive tract and being expelled with the feces. In the urine of man the bismuth is not discoverable, being entirely eliminated in the feces. Notwithstanding the toxic properties of the phenols, none of these preparations have any toxic action, even if given in daily doses of five grams. This is probably due to the extreme slowness of the decomposition which goes on in the intestine. The author therefore recommends these preparations in all cases where the ordinary preparations of bismuth and phenols were formerly employed.—*British Medical Journal*.

Reviews and Bibliography.

Naphey's Modern Therapeutics, Medical and Surgical, including the Diseases of Women and Children. A Compendium of Recent Formulæ and Therapeutical Directions from the Practice of Eminent Contemporary Physicians, American and Foreign. Ninth edition, revised and enlarged. Vol. II. General Surgery, Gynecology, and Obstetrics. By ALLEN J. SMITH and J. AUBREY DAVIS, M. D. III pp. Price, \$6. Philadelphia: Blakiston, Son & Co. 1893.

Perhaps no one would buy a book on therapeutics that had only truth, reason, and good sense in it. Then it would be so small, comparatively, that the publishers would find little profit in it unless sold at a very high price. This is shown by the tendency of these works to grow with every edition as if in rivalry with the dispensatory itself.

The original work of Dr. Naphey was so well and interestingly written that it would have claimed many interested readers even if its selections had been less judicious than they were. In this work, which continues the name, we have not selections, but collections of views from various authors, albeit from the leading writers and practitioners in all countries. From the immense mass the practitioner or student can select what most strikes his fancy and work out the results for himself.

What we need is a commission to test each medicament as recent investigators have tested chloroform, and then to hunt out some deep place in the sea and dump into it the mountain mass of therapeutic trash that encumbers the shelves of medical libraries all over the world.

We must say of the work before us that it is well gotten up, the print is large, and it forms unusually easy reading.

D. T. S.

A Chapter on Cholera for Lay Readers: History, Symptoms, Prevention, and Treatment of the Disease. By WALTER VOGTEL, Ph. B., M. D., Medical Director and Physician-in-Charge of the Fire Island Quarantine Station, Port of New York, etc. Illustrated with colored plates and wood engravings. In one small 12mo volume. 110 pp. Price, 75 cents net. Philadelphia: The F. A. Davis Company, Publishers. 1893.

This is quite a readable little book, gotten up in clear style and in bold print, so that it is easy and pleasant reading. One might conclude, however, that what with cultures, chemical tests, and some hard technical terms, many lay readers might think it meant for others than themselves.

D. T. S.

A NEW ILLUSTRATED DICTIONARY OF MEDICINE, BIOLOGY, AND COLLATERAL SCIENCES.—Dr. George M. Gould, already well known as the editor of two small medical dictionaries, has now about ready an unabridged, exhaustive work of the same class, upon which he and a corps of able assistants have been uninterruptedly engaged for several years.

The feature that will attract immediate attention is the large number of fine illustrations that have been included, many of which, as, for instance, the series of over fifty of the bacteria, have been drawn and engraved especially for the work. Every scientific minded physician will also be glad to have defined several thousand commonly used terms in biology, chemistry, etc.

The chief point, however, upon which the editor relies for the success of his book is the unique epitomization of old and new knowledge. It contains a far larger number of words than any other one-volume medical lexicon. It is a new book, not a revision of the older volume. The pronunciation, etymology, definition, illustration, and logical groupings of each word are given. There has never been such a gathering of new words from the living literature of the day. It is especially rich in tabular matter, a method of presentation that focuses, as it were, a whole subject so as to be understood at a glance.

The latest method of spelling certain terms, as adopted by various scientific bodies and authorities, have all been included, as well as those words classed as obsolete by some editors, but still used largely in the literature of to-day, and the omission of which in any work aiming to be complete would make it unreliable as an exhaustive work of reference.

The publishers announce that, notwithstanding the large outlay necessary to its production on such an elaborate plan, the price will be no higher than that of the usual medical text-book.

A DICTIONARY OF MEDICAL SCIENCE, containing a full explanation of the various subjects and terms of anatomy, physiology, medical chemistry, pharmacy, pharmacology, therapeutics, medicine, hygiene, dietetics, pathology, surgery, ophthalmology, otology, laryngology, dermatology, gynecology, obstetrics, pediatrics, bacteriology, medical jurisprudence, and dentistry, etc. By Robley Dunglison, M. D., LL. D. New (twenty-first) edition, thoroughly revised and greatly enlarged. With the pronunciation, accentuation, and derivation of the terms. By Richard J. Dunglison, A. M., M. D., LL. D.

ABOUT October 15th a Medical Directory of the State of Connecticut will be issued by the Danbury Medical Printing Company, of Danbury, Conn. It will contain a list of all the medical practitioners of the State, the various medical societies, all the dentists and dental societies, druggist and pharmaceutical societies, nurses and training schools for nurses, hospitals, etc. Price \$1, delivered free by post.

THE THEORY AND PRACTICE OF MEDICINE, prepared for students and practitioners, by James T. Whittaker, M. D., LL. D., Professor of Theory and Practice of Medicine in the Medical College of Ohio, etc. New York: Wm. Wood & Co. Cloth, 8vo, 821 pp. For sale by John P. Morton & Co.

Pediatrics.

In Charge of Henry E. Tuley, M. D.

A CASE OF SCARLET FEVER IN PREGNANCY, WITH INFECTION OF THE FETUS.—(Drs. Ballantyne and Milligan, in *Edinburgh Medical Journal*.) A primipara aged twenty, about six months pregnant, had a distinct attack of scarlatina. Three days after onset of fever labor set in, and patient was delivered of an immature infant. Delay occurred when head reached perineum; forceps used; considerable hemorrhage occurred before and after delivery of placenta. Temperature range was from 103° F. to normal—a slight rise on sixth day being due to commencement of mammary secretion. Rash noted on infant on second day, glands at angle of jaw swollen, and mucous membrane of mouth red and dry. Desquamation began same day as that of mother. Eighteen similar cases are recorded.

The authors come to the following conclusions:

1. When scarlatina occurs in pregnancy the fetus *in utero* is usually, but not invariably, affected.
2. It would seem that the infection of mother and fetus is practically simultaneous, for the infant at birth shows the fever in the same stage as that reached in the mother, and desquamation usually occurs at the same time in both.

NOTE.—Dr. Ballantyne has come to the same conclusion with regard to fetal measles; *vide* paper in *Archives of Pediatrics*.

3. The clinical features of scarlatina in the fetus and new-born are the same as in later life; but the diagnosis is rendered difficult by the resemblance these symptoms bear to the normal conditions (erythema, desquamation, etc.) met with in the neo-natal state.
4. The prognosis as regards both mother and fetus is grave, but death does not invariably occur. The supervention of septicemia is the greatest danger, and the chief treatment should be its prevention.

APPENDICITIS IN CHILDREN.—(Dr. John B. Deaver, in *New York Medical Journal*.) The author's excuse for selecting this important subject for elaboration is, "that the disease is one which occurs frequently in early life, and from some similarity of symptoms is likely to be confused with and mistaken for some one of the various intestinal disturbances peculiar to children; because the gravity of the disease is such that upon its early recognition depend in a great degree the chances of recovery; because I desire to advocate the removal of the appendix in acute primary attacks as soon as the disease is recognized, where there has been no decided response to judicious medical treatment and between attacks in all recurrent cases."

He groups under the term appendicitis all inflammatory conditions of the right iliac fossa, and classifies them catarrhal, ulcerative, perforative, tubercu-

lar, and relapsing or recurrent. He gives the following conditions from which appendicitis must be differentiated: enteritis, involving all the coats of the intestine (entero-peritonitis); acute mechanical intestinal obstruction; perinephritic abscess; abscess of the kidney, especially if a floating one; abscess of the abdominal parietes; psoas abscess; hip disease; hepatic and renal colic. Under medical treatment he advises free administration of purgatives, frequent and small doses of salines (preferably Rochelle salts) or small doses of calomel. If an anodyne is absolutely indicated it should be given in as small doses as possible. Diet he limits throughout the disease to peptonized malt, koumyss, milk, and carbonated lithia water, liquid beef peptonoids, and concentrated beef tea, indicated on account of its laxative effect. Buttermilk is given often and is found grateful.

He argues that the removal of the appendix is indicated because the percentage of mortality in operations of recurrent appendicitis is less than one per cent, because the operation is simplified by the absence of inflammatory conditions entitling it to be classed as a simple wound. The post-operative treatment consists for the first three days of alimentation alone, absolutely no opiate, and the administration at this time, if indicated, of one-tenth-grain dose of calomel every one or two hours until the desire to defecate is produced, when an enema is given. He rightly limits the operation to be undertaken by one who is thoroughly prepared to dispose of any unlooked-for conditions likely to be met with. He lays the proper emphasis upon the rapid and thorough performance of appendicial operations, as should be the case in all operations, especially in those performed upon children. The technique of the operation he considers in detail.

THE INDICATIONS FOR TRACHEOTOMY AND INTUBATION.—(Dr. E. H. Stevens.) The author gives a list of 35 cases of tracheotomy and 30 of intubation as performed by himself. He has never done tracheotomy since his first intubation, but believes there are times when the former operation is preferable, and in some cases he has regretted that tracheotomy had not been done instead of intubation, on account of the difficulty of keeping the tube in place, the filling up of the tube, and having to remove it to get away obstructions. His experience leads him to believe that feeding by the mouth can only be carried on in about fifty per cent of the cases of intubation, and where employed it will be found safer to use semi-solid instead of fluid foods.

The following is a *résumé* of the results in tracheotomy: 35 cases, 19 males and 16 females; 25 deaths; 10 recoveries, 6 males and 4 females. Ages of their recovery: 7, 2, 6, 5½, 7, 5, 2, 4, 6, 6. Cases 18 and 32 were the same patient. Second operation done just one year after the first. Months in which the recoveries took place: February, 1; April, 1; June, 1; July, 3; September, 1; November, 3.

The following is a *résumé* of his intubation cases: 30 cases, 18 males and 12 females; 19 deaths; 11 recoveries, 6 males and 5 females. Ages of those

recovering: 6, 6, 4, 7, 4, 6½, 5, 11 months, 17 months, 6, 4. Months in which recoveries took place: February, 1; April, 1; May, 2; July, 3; August, 1; October, 1; November, 2.—*Boston Medical and Surgical Journal*.

TREATMENT OF WHOOPING COUGH.—Anent the editorial in a recent issue of this journal on Pertussis and its Treatment by Bromoform, in the New York Therapeutic Review, No. 3, is a clipping from the Lyon Medical Journal upon the treatment of pertussis by rectal injections of carbonic acid. The author, A. Berjeon, advises, that immediately after the coughing fits, if three hours have elapsed since the last ingestion of food, a gaseous injection of one or two liters of gas CO₂ be given, and states that the child may eat immediately after the injection, which does not in the least impair the digestive functions. If another coughing fit occurs he repeats the injection after an interval of four hours, and in cases of intense whooping cough he follows with the same treatment every attack, renewing the operation as often as five and six times in twenty-four hours.

He affirms that the gravest case of whooping cough seldom resists this treatment for a longer time than a week. He reports the cases of an adult and two of his children, which improved rapidly after two daily applications of the gas, the disease having remained stationary for three months.

CRYING IN CHILDREN.—The cry of children, according to Dr. E. C. Hill, in pneumonia and capillary bronchitis is moderate and peevish and muffled, as if the door were shut between child and hearer. The cry of croup is hoarse, brassy, and metallic, with a crowing inspiration. That of cerebral disease, particularly hydrocephalus, is short, sharp, shrill, and solitary. Marasmus and tubercular peritonitis are manifested by moaning and wailing. Obstinate, passionate, and long-continued crying tells of earache, thirst, hunger, original meanness, or the pricking of a pin. The pleuritic is louder and shriller than the pneumonic, and is evoked by moving the child, or on coughing. The cry of intestinal ailments is often accompanied by wriggling and writhing before defecation. Exhaustion is manifested with a whine. Crying only, or just after coughing, indicates pain caused by the act. The return or inspiratory part of the cry grows weaker toward the fatal end of all diseases, and the absence of crying during disease is often of graver import than its presence, showing complete exhaustion and loss of power. Loud screaming sometimes tells of renal gravel.—*Ontario Medical Journal*.

SQUINT IN CHILDREN.—The editor of the Kansas Medical Journal says: Squint in children should be corrected early in life. If let go for a number of years there is apt to be functional impairment of the retina due to imperfect visual impressions conveyed to the nerve centers. An error of refraction may be the cause of imperfect retinal images. Correct the error and the development of the retina continues and the squint is corrected.

We have fitted glasses to children three years old. True, it is not so satisfactory as when they are older, and there is liability of breakage and injury to the eyes by broken glass and frames, but so far this has not happened in in our practice.

If glasses fitted under atropine fail to correct the squint after a few months' trial, or the error of refraction can not be corrected, an operation should be done if the squint is unsightly.

In case of lack of development and where the lenses improve the vision, we may promise marked improvement eventually when full correction is made.—*Maryland Medical Journal*.

Abstracts and Selections.

SCOTTISH MEDICINE IN THE DAYS OF QUEEN MARY.—Professor Grainger Stewart, of Edinburgh, has published an article on the above topic in Blackwood's Magazine for this month. It appears to have been a presidential address delivered before the Harveian Society of the northern capital. The apposition of the ideas involved in mentioning the beautiful and unfortunate Queen of Scotland and those connected with the decay and disorder of the human frame appears at first sight inharmonious, but when we reflect that

"The boast of heraldry, the pomp of power,
And all that beauty, all that wealth e'er gave,
Await alike the inevitable hour,
The paths of glory lead but to the grave,"

our injured sense of the æsthetic recovers itself and we peruse with *sangfroid* an account of ailments affecting a person whom from our infancy we have imagined as surrounded by every element of romance. Every reader must have a great sympathy for the brilliant and beautiful heiress of the Stuarts returning widowed from the garden-land and brilliant court of France to the Scottish mists and acrimonious wranglings of hard-headed people in the throes of a constitutional and ecclesiastical revolution. The throne of Scotland "cam' wi' a lass" to the Stuarts, and it was prophesied would "gang wi' a lass," and that "lass" would have required stronger nerves than Mary Stuart appears to have possessed had she been able to thrive among the rough baronage of the period. She appears, moreover, to have brought with her from France the seeds of an ague, which later gave rise to a "hardness in her side," suggestive of splenic enlargement. Her return to Scotland was no doubt followed by her making many "new acquaintances," but the first so-called "new acquaintance" seems to have been a disease indistinguishable from influenza, which appears to have been epi-

demie at the time. The unsatisfactory alliance with Darnley and her subsequent regard for Bothwell appear to have so unsettled her nervous system as to have produced the phenomena of *grande hysteric* to such an extent as to render her early demise probable. Inherited gouty tendencies showed themselves later, and the Queen underwent beneficial treatment at Buxton; but, as we know, the axe of the headsman interrupted the progress of pathological changes in the royal patient. In the exhaustive account which Professor Grainger Stewart gives of the illness of John Hamilton, Archbishop of St. Andrews, there is interesting incidental mention made of Jerome Cardan, the Milanese physician, whose pathological ideas may have been crude, but whose therapeutics appear to have been eminently sensible. The Archbishop, it appears, overworked by ambition and by overeating and drinking, developed an annoying asthma, and through the intermediary of Dr. William Cassanate, consulted Jerome Cardan, whose progress from Italy to Scotland seems to have been that of an Æsculapian demi-god. Arrived, he prescribed, together with demulcents and carminatives, the incinerated "lungs of a fox"—a "pulmonin" which we must, perhaps, refrain from deriding in the present day. His successful treatment of his patient seems, however, to have depended upon his regulation of the habits of the former as regards food, rest, and exercise. In order that regularity should be observed in these matters, his Grace was recommended to procure a clock and to live by it. It is unfortunate for some reasons—not for many—that his Grace's prospects for longevity were interrupted by the richly deserved gibbet. As regards disease in general, humanity, built on much the same plan then as now, seems to have suffered much as we do; the exceptional scourge being the plague or pest, in which term fevers other than the oriental plague seem to have been included, and in the endeavor to prevent which some elementary notions of hygiene and isolation seem to have been known to the municipal authorities of the period. For a fuller consideration of the medicine of the period, and some account of its medical worthies, we must refer our readers to Professor Grainger Stewart's interesting sketch.—*London Lancet*.

A DISASTER HAPPILY AVERTED.—The editor of the Medical Mirror, commenting upon some cases of chancre of the lip reported by Dr. Bulkley, says: "The above recalls to my mind an experience in my own home some twelve or thirteen years ago. With an only child to which I was devotedly attached, we had in our employ a house-servant, the chief objection to whom was her coldness and seeming lack of love for children. We felt that however good and faithful a worker she might be, that this one objection was not to be overlooked; however, she remained with us several months, and to my knowledge a young gentleman of excellent family connection visited her of evenings. She was warned against him on the ground that his intentions could not be honorable; however, his visits from time to time continued, she believing that we were in error in our judgment.

One morning the maid presented herself in my office asking for some soothing salve for an annoying ulcer on her lip. It was angry and indurated, and yet did not arouse my suspicion until several weeks later I was summoned one morning to see her by the announcement that she had an attack of the measles. Investigation soon developed a clear pronounced secondary eruption. The offending ulcer was a distinct chancre received from the young man whose visits had been objected to. The moral was distinct and never forgotten. From that time in our family, affectionate manifestations upon the part of housemaids to children were not insisted upon, and we felt gratified in the knowledge of the fact that there had been no bond of sympathy between the girl and our child."

POISONING BY AMYL NITRITE.—A very interesting case is recorded by Dr. Shoemaker in the *Medical News*, of Philadelphia, of May 20, 1893, of a patient who by mistake took a teaspoonful of undiluted amyl nitrite. Such a case is exceedingly rare and is worthy of note. Three minutes after the drug had been taken Dr. Shoemaker found the man sitting in a chair with a moderately flushed face, a pulse of 112, and complaining only of a little headache. He was successively given several glasses of warm water, a hypodermic injection of one eighth of a grain of apomorphine, mustard, and warm water, zinc sulphate in warm water, another eighth of a grain of apomorphine, and more mustard and warm water—so that just seven minutes after he took the drug copious vomiting of a large unmasticated meal occurred. The evacuated matter emitted a strong odor of amyl nitrite. Digitalis and brandy were then injected beneath the skin, and the patient was put to bed and surrounded by hot bottles. His face was moderately blue, and the extremities were cold; the respiration was shallow, but regular; and the pulse was weak and intermittent, but only 68 to the minute. Sulphate of strychnine in doses of $\frac{1}{30}$ gr. was frequently repeated. Two hours later the pulse had ceased to intermit and the patient rapidly recovered. Consciousness was not lost at any time, though the man seemed drowsy and stupid. There were no twitchings or convulsions or irregularity of respiration. The man was constantly watched and every symptom carefully noted as to time, a record of the pulse being taken every five minutes, but no symptoms beyond those related developed.—*London Lancet*.

MEDICAL PROGRESS.—In a recent valedictory address at Glasgow University, Professor McKendrick summed up the results of the development of medical knowledge during the last thirty years as follows: "Thousands of lives saved annually by preventive medicine; greater accuracy in diagnosis, and a sounder knowledge of the natural history of disease; more rational treatment; many diseases caused to pass through their stages more speedily, thus saving time; better means of relieving pain and suffering; and making disease, even when incurable, more tolerable, and at last smoothing the passage to the Elysian Fields."—*Boston Medical and Surgical Journal*.

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"NEC TENUI PENNÂ."

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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THE NEW MEDICAL PRACTICE LAW AND THE SECULAR PRESS.

A respectable number of the secular papers of the State have given utterance to their disapproval of the act governing the practice of medicine in this State that has recently gone into operation. While we must admit that much they say in regard to indirect advertising on the part of many who claim to be regular, and some who even assume to be censors, is true, with a right understanding of the case they can not fail to see that they occupy an untenable position. Underlying all animadversions on the new law that we have seen is the assumption that the act was passed wholly in the interest of the medical profession. If this assumption were correct, the law ought never to have been passed, and furthermore ought to be repealed at the earliest practicable opportunity. The medical profession has no right to invoke class legislation which inures to the injury of the masses of the people, whether such legislation is obtained covertly or openly.

But we deny that such legislation is in the interest of the physicians of the State except as they are benefited by the common good. On its face it does look like a very fair proposition that a physician should be allowed to advertise as freely as his neighbor who sells dry goods or groceries, and that he should be allowed to hawk his skill and knowledge over the country as freely as the drummer offers his samples of

whisky or tobacco. But when more closely examined the cases are entirely different. The man who sells goods offers that which can be examined and proved before harm is done, and if he be a fraud exposure is easy. On the other hand, the man who offers cure for all manner of diseases offers that which to the majority of the people can only be rightly judged of after they have spent their money and lost precious time. It may be that not all peripatetic advertisers are quacks and frauds, but every one at all acquainted with the possibilities of medicine well knows that a majority of them, amounting to well-nigh the total, are frauds and ignoramuses. The people upon whom they are wont to prey are mostly in a state of mind to render them easy victims of misrepresentation and fraud. "All that a man hath will he give for his life" is as true to-day as when first spoken, and men suffering from incurable diseases are usually in a state of mind to look favorably upon every offer of help, it matters not how absurd or unreasonable. It is these who are ever the victims of the peripatetic quack. Then there are thousands who are adroitly made to believe that they suffer from dangerous diseases when in fact their ailments are most trivial. These too are ready victims and ready witnesses also to wonderful cures from alarming diseases that existed nowhere else except on the tongues of these vampires.

The writers who favor a large license to these men can not certainly be acquainted with the false promises they make, with the impossibility of the cures they promise, and the utter heartlessness with which they are willing to wring the last penny from the fears of the most pitiable victim. As a rule, with exceptions so few that the term scarce need be used, they are to medicine what the forger and the counterfeiter are to business. If one of the papers who advocate the cause of these quacks were asked to insert an advertisement of green goods or of burglar's tools, the editor would take it as a deadly insult, and yet the class for which it pleads would go down in every fair comparison with the burglar or the counterfeiter. It must be conceded that physicians have no right to invoke the laws of the State to punish violations of the Code of Ethics, but it is the right of the people to be protected from plunderers, and until a measure is put in force appointing a competent commission to pass upon the character of promises that may be made to the public the best and the easiest way to avoid the evil is to shut out the entire tribe of peripatetic quacks.

Notes and Queries.

THE MYSTERY OF CHRONIC CONTRACTED KIDNEY.—One death in twenty is due to kidney disease. In adults the proportion is much higher. The interest in the kidney and its workings is therefore very great, not only in the profession but in the laity. The liver kills its hundreds, the stomach its thousands, the kidneys their tens of thousands. Leaving out of consideration the mortality from intestinal diseases among children one finds that the organ of least resistance is the lung. Lesions of this important viscus are the cause of over one fourth human mortality. The nervous system gives out next. Following this come the heart and kidneys, which are about equally active as agents in mortality. These facts suggest a possibility that people, including physicians, who are careful about their health think too much of their stomachs, their livers, and their constipation, and too little of the way in which the kidneys are behaving.

This is the teaching of a lecture on "The Mystery of Chronic Contracted Kidney and the Secret of its Prevention," delivered by Dr. H. C. Wood and published in the University Medical Magazine. We trust that the author is not altogether responsible for the title, which is somewhat expansive for a scientific publication, for we do not find that he has removed any new veil enshrouding the Isis of renal pathology and therapeutics. Dr. Wood, however, does show happily and impressively the fact that contracted kidneys often develop insidiously, perhaps by jumps and starts and in unexpected ways; also that the causes may be poisons engendered within from overfeeding, malassimilation, indigestion, etc., as well as from exposure to the ordinary extrinsic poisons, such as alcohol and lead. One should watch the kidneys, looking out for temporary albuminuria, hyaline casts, and low specific gravity. The writer gives this impressive illustration:

"Some years since one of the most graceful lecturers who ever adorned a chair in the Medical Department of the University of Pennsylvania had occasion in the lecture-room to use in a control experiment normal urine, and selecting his own for the purpose unexpectedly found that he was the subject of chronic Bright's disease. He had supposed himself in perfect health, but not very many months later died of uremia. Such an occurrence as this," Dr. Wood adds, "parallels what happens not very rarely in the daily routine of medical practice. Every practitioner who sees much of chronic diseases must, time and again, meet with cases in which contracted kidney is not detected until the later stages of the disorder are reached."

As for the secret of the prevention we find that Turkish baths, habitual bathing, exercise, and moderation in eating are recommended. And no one can take exception to such advice.—*Medical Record.*

A SPECIAL FORM OF PHLEGMON OF THE NECK.—Drs. Brousses and Brault describe a space of prismatic form, situated below the back part of the tongue and bounded in front by the hyoglossal and thyrohyoid membranes, and behind by the anterior surface of the lower and attached portion of the epiglottis. (*British Medical Journal*.) The upper boundary is formed by two membranous layers, one consisting of the lingual mucous membrane, the other and deeper layer of fibrous tissue. This cavity, it is stated, is divided into two lateral halves by a membranous septum, which seems to be an extension downward of the median glosso-epiglottidean ligament. This enclosed and divided space, which is called by the authors the glosso-thyro-epiglottidean cavity, may, it is stated, become inflamed, and thus give rise to diffused phlegmon of the neck. Phlegmon, when developed in this cavity, presents in its early stages a special set of symptoms, which may enable the surgeon to form a precise diagnosis. These characteristic symptoms, which in the course of the affection become associated with intense dysphagia, dyspnea, and aphonia, are: (1) Spinal localization of the swelling and tenderness in the portion of the neck between the suprahyoid and infrahyoid regions; (2) a "woody" consistence of the swelling, due to the fact that it is closely and deeply limited by membranous walls capable of withstanding tension; (3) slight infiltration in the glosso-epiglottidean region, while the surgeon is unable to feel any elevation there or any collection of effusion in process of formation; (4) absolute integrity of the root of the tongue and of the pharynx. This form of phlegmon is a serious one, as asphyxia is threatened in an early stage of the affection, and septic poisoning at a later period. The treatment should consist, when the inflammation is still limited to the cavity, in thyrohyoid laryngotomy, and afterward, when the swelling has spread above the hyoid bone, and can hardly be distinguished from that of deep-seated phlegmon in this region, in a median incision carried between the geniohyoid muscles to the base of the tongue.

THE PHYSIOLOGY OF WEARINESS.—In delivering the Rede Lecture at Cambridge on the 14th inst., Professor Michael Foster chose as his theme "Weariness." Those acquainted with Professor Foster's works and the combined breadth and caution of his generalizations will know that no one could have been selected who was more likely to do justice to a subject which has a personal interest for every worker. Commencing with a simple muscular act, the lecturer analyzed the physiological phenomena of weariness in such and in the higher work of mental operations. He clearly emphasized the two prime factors in the production of exhaustion—too rapid expenditure of capital or force and the accumulation of the products of activity in the working organ. After proving that "the nervous system was a candle which could not profitably be burned at both ends at once," Professor Foster went on to show that endurance depended largely upon "blood adequately pure," and that the readiness with which the "internal scavengers freed blood from the poison which the muscles (and other active

organs) poured into it" was proportionate to the staying power of the worker. "The hunted hare died, not because he was choked for want of breath, not because his heart stood still, its store of energy having given out, but because a poisoned blood poisoned his brain and his whole body." The "humbler helpmates" of the active organism—that is, the nutritive, excretory, and metabolic functions of the body—were of the highest importance to the enduring activity of the higher executive mechanism. Professor Foster touched upon, but did not treat, the subject of "inertia or laziness," and we trust that he will on some future occasion afford us the benefit of his views upon this phase of the subject. That "unwillingness to stir" greatly increases the work of compulsory stirring, is matter of constant observation, and the "labor of love," though greater than that of compulsion, may be borne with much less effort and with much less weariness than the latter.—*London Lancet*.

OHIO STATE MEDICAL SOCIETY.—At the last meeting of the Ohio State Medical Society the following officers were elected: President, N. P. Dandridge, Cincinnati; First Vice-President, F. C. Larimore, Mt. Vernon, Second Vice-President, William Caldwell, Fremont, Third Vice-President, W. F. Corlett, Cleveland, Fourth Vice-President, S. S. McCurdy, Dennison; Secretary, Thomas Hubbard, Toledo; Assistant Secretary, Charles Graefe, Sandusky; Treasurer, J. A. Duncan, Toledo.

Special Notices.

I AM glad to state that I have formed a high opinion with CACTINA PILLETS. One case in which I tried them was an old gentleman who has been suffering from valvular disease of the heart, and who for over four years has never been able to leave off taking some form of heart tonic. Latterly he had been taking strophanthus, but a month ago it brought on diarrhea and we had to leave it off. Digitalis he could not take, and having tried strychnia and various other remedies without doing any good, I resorted to CACTINA PILLETS. I gave him a bottle of one hundred pillets, and marked improvement resulted, and since then he has taken more. He himself says he is stronger and better than he has been for years, for proof of which is that he can now walk about his grounds, whereas he formerly had to be wheeled in a bath chair. One of my favorite prescriptions is the following:

R Cactina Pillets, 20;
 Ammon. carb., 30 grains;
 Spts. chloroform, 1½ drams;
 Tinct. columbæ, 2 drams;
 Aqua q. s. ad., 8 ounces.

M. Sig: One ounce three times a day.

T. GORDON KELLY, M. D., A. B., etc.,
 The Priory, Desford, Leicester, Eng.

HERPES ZOSTER.—Dr. Ohmann Dumesnil, in a valuable article on Herpes Zoster in the Quar. Atlas of Derm., recommends Peacock's Bromides as a nerve sedative when the prodromic symptoms appear.

THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNĀ."

VOL. XVI.

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No. 9.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

MELANCHOLIA.*

BY P. F. BARBOUR, A. B., M. D.

Demonstrator of Chemistry in Hospital Medical College.

"Melancholia is a form of insanity whose essential and characteristic feature is a depressed, that is, subjectively arising, painful emotional state which may be associated with depression of other nervous function." It is not met with frequently in general practice, but it concerns so deeply the happiness of the patient and his friends because of the odium which so unfortunately attaches to it, and also because of its frequent tragic end, that it merits our careful study. We have all had our spells of the "blues," but they are not to be compared with the intense mental suffering and terror which at times seem to paralyze the melancholiac. There is no physical pain comparable with his mental agony, and yet the beginning rack and ruin of the mind often starts with the "blues."

We must be able to diagnose melancholia before the advent of delusions, for the old adage, "A stitch in time saves nine," is especially true in the treatment of insanity. It is to a few points in the early diagnosis and the treatment of melancholia that I ask your attention to-night.

With the general etiology of melancholia you are familiar, and it is of the less interest to us in that it is very rarely that any of the various factors in its causation can be obviated or mitigated, because we are usually called too late, owing to the reluctance of people to confess

*Read before the Louisville Clinical Society, September 26, 1893. For discussion see p. 343.

that any of their family is so afflicted. It is business worry and ill health that frequently overcome men. It is physical weakness after gestation, lactation, etc., in women that acts as a predisposing cause, too often seconded by family troubles. But when does the grief natural to such circumstances overstep the boundary line and become an evidence of disease? This is an important question for us to decide.

My attention was called several years ago to an important symptom-group as a sign of impending danger, and I have confirmed its value by subsequent asylum experience. The group is insomnia, mental depression, and occipital headache. It is the conjunction of these three symptoms that is of diagnostic importance, though the presence of any one should arouse our suspicions.

Insomnia stands in the relation to melancholia both of cause and effect. Its close connection with all forms of insanity is so well understood that it requires little further comment. It is important, however, to note that melancholiacs frequently lie for hours with eyes closed, and yet not asleep. This is not due to a voluntary attempt at deception, but comes from their disposition to remain in any position they have assumed. Often in chronic cases they will complain of having been awake all night when there is every reason to suppose that they have been asleep. Generally their appearance denotes whether they are getting sufficient rest or not. At the same time insomnia is of too frequent occurrence among the sane to make us suspicious of a case unattended by other unfavorable symptoms.

Likewise gloomy forebodings and fearful anticipations of the future, with remorse for the past, may excite our apprehensions, and yet be merely an exaggerated pessimism; but if a mother displays acute grief for a daughter who has been dead for years, and says she killed her, it is at once recognized to be unnatural, or when a man suddenly, without reflection or counsel from friends, becomes convinced that he is a terrible sinner, without hope in this world or the next, it is significant of insanity.

But our diagnosis will be rendered practically certain if the third leg of the tripod is present, occipital or postnuchal headache. The severity of this headache, as a rule, does not approach that of the so-called bilious headache, but is more often simply a tenderness consequent on or independent of pressure. This symptom is present generally before the patient has had any delusions, and is thus a valuable danger signal.

Other symptoms of melancholia, such as loss of memory and loss of interest in their families or friends, or disinclination toward favorite sports and amusements, are usually present, and serve to put us on guard; but the degree of abstraction of each person is difficult to gauge unless we are thoroughly familiar with his eccentricities, whereas the three symptoms upon which stress is laid are not liable to deceive, and hence are of the more service. When a patient has well-developed melancholia it requires no skill to recognize it, but the best time for treatment has been lost.

The prognosis of melancholia is quite unfavorable, as only sixty per cent of recent cases in asylum practice recover, though the prognosis as to life is much better. I have no doubt that with its early recognition and treatment a much larger percentage of recoveries can be maintained.

There are several important considerations in the treatment of melancholia, the most prominent of which is, shall the patient be treated at home or at an asylum? The answer must depend upon the environment and the peculiarities of the individual. If the family have the means and are disposed to do every thing in their power for the betterment of the afflicted one, he has the best chance at home. But ample provision must be made against possible suicide or homicide. As a rule it is not difficult to nurse a melancholiac, if a quiet one; but if the patient has the agitated form he will do much better in an asylum, where he will be protected against himself, and the danger to the family will be removed. We must consider the family as well as the patient.

When we examine a melancholiac we note, in addition to his mental symptoms, that his skin is dry, rough, and scaly, his tongue is heavily coated, his bowels are constipated, his extremities are cold, and his bodily temperature is below normal. Every organ of the body seems to be sluggish, and thus shows the extent to which intense activity of the brain can inhibit that of the other organs. Our object should be to allay the excessive activity of the brain and to stimulate the visceral organs to their duty.

It is true of the nervous system, that when it is run down from lack of nutrition or other cause it never returns to the normal condition until the other systems are in perfect condition. A patient should improve as his physical health improves, and a patient who accumulates flesh and does not at the same time show mental improvement is gen-

erally past hope. Thus nourishment is our aim, and at the same time measures our progress.

It would be unprofitable to detain you with elaborate dietaries, for every one is a law to himself, but I must emphasize the value of frequent feeding. It is well known that slight stimulation frequently repeated will often secure more work from an organ and leave it in better condition than a large amount given at one time. So light meals served frequently will arouse the digestive system much better than the time-honored three meals a day. Mitchell's system of forced feeding with massage will sometime produce brilliant results. Hydrotherapy also meets some of the indications, and no doubt is of value. Frequently, however, the patients utterly refuse to eat, owing to some delusion with regard to the food, and the question of feeding by force will engage our attention. It is better in every instance to resort to force rather than have the patient lose any nourishment. There must be no half-way measures adopted, and frequently the patient who realizes you are in earnest will cease to resist. In forcible feeding the most concentrated and nutritious liquid foods should be used. Often a patient can be fed with a feeding-cup, although he objects strenuously. If the feeding-cup is not sufficient, the stomach tube may be resorted to. It should be of large caliber, the larger the better, as it produces less gagging, is not so apt to enter the trachea, and feeds more rapidly. It is noticeable that these patients are much more tractable and appear better when their stomachs are full. They are always better in the afternoon when they have had food regularly through the day than in the morning when they have suffered from the long night's fast. They are much more apt to commit suicide in the early morning than any other portion of the day, and so require the closest watch at that time. They should have something to eat immediately on their awakening. It may be advisable to prescribe some of the bitter tonics or the digestive agents, but they are indicated in only a few of the cases. Of course all the animal functions must be looked after.

The insomnia of insanity is often a most difficult symptom to treat. There are many kinds of hypnotics, and all are objectionable for one reason or another. Sulfonal is a fairly reliable hypnotic. It is objectionable because it is sometimes too depressant, and when the patient is weak it may be dangerous. The same is true of chloral. When it is difficult to force hypnotics by the mouth, the hydrobromate of hyoscine given hypodermically is very useful. It secures usually from six to

eight hours of refreshing sleep. In melancholia agitata, when the patient is constantly in violent motion, the motor depression of hyoscine is very desirable. I have not been forced to the use of morphine as a hypnotic, but it is a valuable agent in the treatment of melancholia if it is given in minute doses for its exciting effect. It combats the gloomy tendencies and produces a feeling of *bien être*. We should be very careful to keep the patient in ignorance of the fact that he is taking morphine, for fear of a far worse fate.

Traveling is usually not good for these patients; it upsets their digestion, disturbs their rest, and does not overcome their mental absorption. But during convalescence it frequently hastens improvement, and then is of benefit.

The regular hours of food and sleep in an asylum are often of the greatest benefit in cases of acute melancholia, but this very regularity is a disadvantage in the chronic form. It needs stimulation, change of air and food, and even these are usually inefficient.

A recent writer has noticed that certain of his chronic cases who had survived typhoid and other fevers recovered their intelligence even after years of asylum life. Possibly we shall come to inoculations as the *fin-de-siècle* treatment of melancholia.

LOUISVILLE.

SACRO-PUBIC HERNIA.

BY F. BYRON ROBINSON.

Professor of Gynecology in Chicago Post-Graduate School.

It may be well said that prolapse of the uterus is still imperfectly understood. If one will read twenty standard text-books on gynecology with reference to sacro-pubic hernia, he will be astonished at the variation of opinion. He will be surprised at the scarcity of facts and the wonderful accuracy with which one copies the views of his predecessors; in no department of gynecology are views so divergent and non-harmonious. As a matter of course, diverse views as to etiology induce diverse views in removing the well-known effects. One will operate to cure sacro-pubic hernia, the other denounces operation. One says the uterus has nothing to do with prolapse, the other says the heavy uterus is the prime mover in the disorder. One says the cause lies in the lacerated perineum, the other says the perineum has nothing to do with sacro-pubic hernia. Each individual must use his own judgment.

In this article uterine prolapse will be termed sacro-pubic hernia. It is thought that hernia is a more correct and scientific term. Sacro-pubic hernia is a very complicated process. The writer has gone to his gynecological clinic day after day and month after month and attempted to watch how sacro-pubic hernia comes about. It is true one can put a woman with sacro-pubic hernia on the table, reduce the hernia, and then have the woman strain and reproduce the hernia. She can reproduce the sacro-pubic hernia in half a minute, whereas it required years to bring it about. As the woman presses the organs out we observe that the anterior wall of the vagina come in sight first; second, the lower end of the cervix appears, next, and lastly, the posterior vaginal wall rolls into view. In general it may be said that sacro-pubic hernia comes about in the same manner that the patient reproduces it after it is returned to the pelvis. To understand sacro-pubic hernia one must know thoroughly pelvic anatomy, the most difficult of all anatomy. The escape of the uterus and vagina from the pelvis must be studied as an engineer studies his engine or as a carpenter studies how to build a house; but it must be studied on the living woman who has a sacro-pubic hernia. The pelvic floor is the battle-ground of study, and it will surprise the novice how much downright hard study it will demand before very many clear visions of how the organs descended will appear. The pelvic floor is made up of the levator ani, with the rectovesical fascia above and the anal fascia below it. There is an elliptical aperture in this muscle (the pubio-coccygeus) through which a canal (the vagina) leads to the vulva. Sacro-pubic hernia comprehends the idea that the vagina and uterus must glide out through the slit in the muscle. The uterus rests on the compact pelvic floor. It is not hung or slung. The most comprehensive views are obtained by dividing the pelvic floor in an anterior and posterior segment. The anterior segment is composed of retro-pubic fat, the bladder, and the anterior vaginal wall. It will be observed that there the elements are all loose in their attachments. They compose the real movable pelvic segment or valve of the pelvic floor. This segment moves with the viscera. The posterior segment of the pelvic floor is composed of the posterior vaginal wall, the perineum, and the rectum. Observation shows this segment quite fixed in its attachments. It is the real immovable segment or valve of the pelvic floor. Now, the anterior pelvic segment rests on the posterior, and the uterus could not be forced out unless these valves, the anterior and posterior segments, open. These valves are opened

up naturally by labor. They are opened up artificially by putting a speculum into the vagina and allowing the air to rush in, and they are opened up pathologically by sacro-pubic hernia. If one watches the patients in a gynecological clinic strain he will surely observe that the vagina bulges out first, so that in a chapter on sacro-pubic hernia one must include the vagina as well as the uterus.

Again, by a more careful study of cases of sacro-pubic hernia he will soon find that another factor is very frequently present, viz., cervical hypertrophy. Therefore the chapter of sacro-pubic hernia will include three matters—(a) vaginal, (b) uterine prolapse, and (c) hypertrophic elongation of the cervix. Of course nearly all women who have prolapse are child-bearing women, and subinvolution of pelvic organs and tissue is the prime mover in the disorder. The three prime factors in the causes of sacro-pubic hernia are: (1) Intra-abdominal pressure; (2) loss of tone in the anterior pelvic segment (bladder and vagina), and (3) deficient support in the sacral segment, that is, straightening out of the sacral segment and laceration of the perineum.

1. The first element in prolapse is the vagina, so far as I can observe. If one tells the woman to strain while on the examining table, the bulging vagina is first pushed into view; intra-abdominal pressure forces it out. In such cases the the vagina is (a) hypertrophied from subinvolution or congestion; its walls are thick and heavy. (b) The vaginal walls slacken, which means they become vascular or edematous. (c) The connective tissue around the vagina becomes loose; the vagina is not held fast by the tissue. Thus, from hypertrophy and slackening of the vaginal wall it is forced out by abdominal pressure because its connective tissue fastenings are loosened or absorbed. Of course the bladder follows the vagina down.

2. The second element of sacro-pubic hernia is the forcing of the uterus after the vagina by abdominal pressure. The size and weight of the uterus has little to do with prolapse. The uterus is large simply from subinvolution. If a heavy uterus prolapsed, then fibroid uteri would descend; but few would claim that. Then the uterus hypertrophies from congestion due to prolapse. Again, the large uterus retroverts, which is the very condition of prolapse, for then the cervix can act as a wedge.

3. The third element in sacro-pubic hernia is hypertrophic elongation of the cervix. The cervix will elongate many inches. So far I do not understand the pathology of the hypertrophy of the cervix, but I

know it occurs, and see it in the gynecological clinic. I hope more study will enable me to gain some logical reason for it. The cure for prolapse which I now use is operation. I first denude an oval space on the anterior vaginal wall and unite the edges. That narrows the vagina, directs the cervix toward the sacrum, and raises the bladder. Second, if necessary, the cervix is amputated. The cervix is amputated so that it will point toward it, for so long as it points in the vaginal canal it will act as a wedge to expand it continually. Every breath or cough shoves the cervix into the vagina; by cutting off the point of the cervix it will have a broad surface and will rest on the perineum. Third, I do a Tait's flap operation so as to extend the perineum almost up to the urethra. The flaps should be made by deep cuts, exposing wide areas of tissue for union by silk-worm gut sutures, which I prefer to leave in from four to six weeks.

CHICAGO, ILL.

RECTAL HEMORRHAGES IN WOMEN.*

BY W. SYMINGTON BROWN, M. D.

When bleeding takes place in the rectum it usually proceeds from hemorrhoids. A rectal polypus may be the cause; but this is a rare occurrence. I have only seen two cases during the last thirty years. Cancer and syphilitic stricture may end in rectal hemorrhage, and bleeding may occur from anal fissures.

Piles are not confined to women. Young and middle-aged men are also subject to this affection; but, on account of the larger supply of blood to the pelvic organs in women and the prevailing constipation, we are more frequently called upon to treat hemorrhoids in women than in men.

Allow me to refresh your memory concerning a few anatomical data: It is natural for an old professor of anatomy to magnify the importance of his calling! The rectum is about eight inches long; narrowest where it joins the sigmoid flexure, and its lower third is not covered by peritoneum. Above the inner sphincter few sensitive nerves go to the mucous membrane; so it happens that the rectum may become much distended by feces without marked suffering. Several years ago I

* Read before the Gynecological Society of Boston, September 21, 1893.

attended an old woman for a colic, who had had no evacuation from her bowels for a continuous period of five weeks; and, quite recently, in examining a surgical case, the man admitted that four weeks had elapsed since defecation. A white, circular line at the anus divides the mucous membrane from the skin, and also serves to mark the separation of the external and internal sphincters. The inner one extends about an inch into the gut.

When the liver is inactive the portal circulation is impeded, and pelvic congestion results. The absence of valves in the hemorrhoidal plexus of veins also favors congestion. And the dense cellular tissue in the lower part of the rectum, full of odoriferous glands, becomes agglutinated by plastic deposits. Varicosity often commences in capillary vessels. Retroversion, retroflexion, and procidentia of the womb, even ordinary pregnancy, tend to produce congestion.

Hemorrhoids may contain veins, capillaries, arteries, lymphatics, nerves, and connective tissue, covered either by mucous membrane or skin. They are usually divided into two classes, external and internal; those situated above the sphincters belonging to the latter class. A small external pile may consist of a vein filled with coagulated blood. This sort can be promptly cured by slitting it up with Syme's lancet and turning out the contents.

Internal piles are generally flat. A circumscribed area of mucous membrane becomes soft, porous, and varicose. The pressure of straining at stool, any extra pressure, forces blood through the diseased tissues, sometimes to an alarming amount.

Many patients are afraid of surgeons and prefer palliative treatment, which generally means any thing. Absolute cleanliness of the anus and rectum serves both as a prophylactic and a palliative. A sitz-bath in hot water (120° F.) for thirty or forty minutes sometimes relieves the pain. Medicine swallowed, ranging from tar pills to ergot, is of doubtful reputation, though frequently given more than a fair trial. I have only found two methods beneficial in certain mild cases: one is to gently and gradually dilate the sphincters, which relieves constipation and tends to check hemorrhage; the other palliative method is to elevate the lower extremities and the pelvis, which arrangement alleviates congestion and promotes absorption by means of rest and position. The return of blood, both by the portal and internal iliac veins, in this way is much facilitated. Elevation of the pelvis and lower extremities may be effected at night by means of firm bolsters and cushions, and

the chances of recovery would be much increased by continuing the position throughout the day as well as at night.

It must be admitted, however, as a general rule, that the best way to treat piles is to surgically remove them. That is the radical plan, and it saves the patient time, money, and distress. There are several ways of doing this. The old orthodox course was by means of ligatures applied to each pile so tightly as to strangulate it. After eight or ten days of agony, partially relieved by opiates, the piles dropped off, and the patient was supposed to be cured. This cruel process (not yet entirely obsolete) is frequently followed by retention of urine and other nervous ailments. The modern method is by means of a clamp and the actual cautery, an improvement on the ligature, but, in my opinion, much inferior to the method I shall now describe.

The bowels are thoroughly emptied by a mild cathartic (compound licorice powder or castor oil), followed next morning by an enema of lukewarm water and glycerine. Sulphuric ether is administered to the surgical degree; the surgeon's thumbs are inserted into the gut as far up as possible, and both sphincters paralyzed by stretching the parts toward the ischia. This should be done slowly, employing at least five minutes. A small roll of iodized wool, with a string attached, is pushed about two inches up the rectum to prevent the descent of feces during the operation. If the pile is pediculated, the wire of an ecraseur is applied to the pedicle and gradually tightened until the included mass is severed. When the pile is sessile, a slight circular incision may be made with scissors or a scalpel before applying the wire. The tightening should always be made slowly, stopping occasionally, in order to avoid hemorrhage.

Paralysis of both sphincters is an essential part of this method. It was first performed in America by the late Dr. Van Buren, of New York, and soon after by Dr. H. R. Storer, of Boston. It is at present a preliminary to most rectal operations performed here. Mr. Bryant, the celebrated London surgeon, denounces it as a barbarous procedure; but I think that that epithet might be more appropriately applied to the old method of tying piles. The only serious risk run is incontinence, and that risk is very small. A slight, smarting sensation is all that the patient feels after the removal of hemorrhoids by the wire ecraseur. The operation is finished at a single sitting, and the patient is able to resume her usual occupation in a week or ten days.

No effort should be made by the surgeon to postpone a motion of

the bowels; but the external parts must be carefully washed twice a day, or oftener, and always after defecation. One of the advantages attendant upon paralyzing the sphincters is the ready access afforded the operator to inspect the tissues thoroughly, and, should much hemorrhage occur, to control it. In women the rectum can be turned inside out from the vagina after dilatation of the anus, and in this way internal piles become as accessible as those which are external.

During the last quarter of a century I have operated with the ecraseur on hemorrhoids twenty-nine times with uniform success. Of these patients five were men and twenty-four were women. The amount of blood lost never exceeded three or four ounces, and secondary hemorrhage never occurred. I do not assert that all cases should be treated in this way, but, as far as my limited experience goes, I am sure that it is a safe and easy plan in the great majority of cases.

STONEHAM, MASS.

Reports of Societies.

THE LOUISVILLE CLINICAL SOCIETY.*

Stated Meeting, September 26, 1893, Dr. I. N. Bloom, President, in the chair.

Dr. J. M. Mathews (Malignant Tumor of the Sigmoid Flexure): Some time ago I was called to Shelbyville, Ind., by telegraph, asking me to see a patient and be prepared to do a colotomy. I made the trip, and was surprised to see the patient at the depot in his carriage to meet me. I found him to be a man about fifty years of age, comparatively a small man, in height especially, weighing probably one hundred and fifty-five pounds. We drove to his home, and I stripped him to make an examination, and while he was preparing for it gave me this history: He said that he had pain nearly all the time over the point of the sigmoid flexure, in the left inguinal region; that frequently it was so severe that he would fall on the street; that he passed blood, mucus, and pus from his rectum; that he could not have a molded action, nor had not had for a number of months; that the fecal mass passed in small pieces, or as a tape line in shape. I put him on the table naked, and in an examination of his abdomen noticed that it was

* Stenographically reported by C. C. Mapes.

of about medium size. Over the colon he had a tumor which seemed to be more or less superficial, scarcely being able to detect any well-defined base. I was deceived by it, because I thought it had something to do with the case. I could not detect any tumor underneath it or in the sigmoid flexure proper.

I said to his physician that I did not believe then was the time to do a colotomy, that by an injection given high up in the colon he could pass feces, as was evidenced by giving him an injection. I gave it as my opinion that he had a malignant tumor in the sigmoid flexure; my reasons were principally from the clinical aspect and history of the case; that the time would come when we would be justified, perhaps, in doing a colotomy. With that diagnosis and prognosis I left him.

A few days afterward he was influenced, partly by his family physician, to go to Chicago and consult an eminent surgeon there in regard to his case. He went according to this direction, and was given a most thorough examination by one of the most distinguished surgeons in America. After that examination the surgeon wrote the following letter to the family physician:

. . . I made a very careful examination of the patient you were kind enough to send to me for my opinion. Rectal examination revealed a catarrhal proctitis and a few small internal hemorrhoids. I could feel no tumor or swelling in any portion of the colon. I made a rectal insufflation, and had no difficulty in forcing air along its entire length and beyond the ileocecal valve. When the colon was distended I again made palpation, with negative results. The prostate is much enlarged. It is possible that he has a simple stricture of the sigmoid flexure, but the future will have to determine a positive diagnosis of this condition. . . .

Now I have contended, gentlemen, for a number of years that no man is able by palpation and the ordinary methods of external examination of the sigmoid flexure to detect a tumor in it. I do not believe that in an ordinary sized abdomen, or indeed I might say when the patient is more or less wasted, it is possible to definitely say that there is a tumor, or a cancer, if you please, in the colon at this point of the flexure. I have been forced to this opinion from examining many cases and failing absolutely to detect a tumor, when afterward by the death of the patient it was revealed that a malignant tumor existed. Therefore I have believed that the only way by which a diagnosis could be reached was by a clinical recitation of the symptoms of the patient, as was evidenced in this man. Now here is a man that will bear out my

theory, if theory you may call it. He was undersize, he did not have a large abdomen, and was examined by one of the most distinguished surgeons, as I say, in America, and he writes the letter quoted above, stating that by insufflation of the bowel, and by as thorough an examination as he is able to make, he decides that there is no tumor of any kind in this man's sigmoid flexure.

Six weeks after he returned home he was taken with sudden pain on the street, fell, and was conveyed to his home, and expired in two hours. Feeling at least a little embarrassment over the case in that I had said there *was* a tumor in this man's flexure, I had asked for a *post-mortem* when his death occurred. Dr. Cook, of Indianapolis, had seen the patient about a month before I did. He believed also that there was a malignant tumor. The family physician promised me that if the man died he would have an autopsy. Upon his death Dr. Cook was immediately telegraphed for. He went to Shelbyville and held a *post-mortem* upon this patient. I have read you the eminent surgeon's letter, and here is the specimen. With this sized malignant tumor in the sigmoid the surgeon failed to detect it. Here is the colon which had bursted, as will be seen, the contents passing into the abdominal cavity, which caused the patient's death.

I cite this case simply to prove my theory that if so distinguished a surgeon as the one who examined this case is unable to make a correct diagnosis, it certainly establishes the point that it is a most difficult thing to detect a tumor in the sigmoid by palpation.

DISCUSSION.

Dr. J. W. Irwin: The eminent authority whose letter you have read is cautious in giving an opinion, and on its face it is a sort of go-between, but it says that "the future will have to determine the positive condition." This seems to me to be the meat of the letter. Further statements on the part of the writer were superfluous, and when used at all could not have enlightened any surgeon. No doubt this part of the letter was intended for the patient and his friends, and so it seems. Such eminent authors should not stoop to methods capable of double meaning, since frankness within the ranks of the profession should be observed as much by such men as by those less endowed by nature's gifts. The opinions of persons of acknowledged wisdom are sure to be repeated, and often to the discredit of humbler though equally well-informed physicians. Dr. Mathews waited for his vindi-

cation, and it came in due time. I think Dr. Mathews undervalues the importance of the diagnostic methods which he employs when he speaks of "theories," as that which can be felt is discovered by one of the five senses, and here theory ends.

Dr. J. A. Ouchterlony: This is a subject in which I am very much interested. I think there is hardly any locality in which tumors may develop that furnishes material of greater interest. I have had occasion in a number of instances to study this very form of disease in this very locality, and I am willing to go with Dr. Mathews so far as to say that undoubtedly there may be a tumor in the sigmoid flexure without the medical man being able to detect it. Nevertheless I am very sure that if the examination is made from time to time the occasion will arise when the tumor can be discovered, and the reason why it is often difficult to find it is in the fact, first, that the sigmoid flexure is so very movable, and secondly, owing to the weight of the tumor it is likely to descend into the intra-pelvis, and then it is beyond our reach. I have found that over and over again. I have not seen as many cases of malignant growths of the sigmoid as my friend Dr. Mathews, still I have seen enough of them to justify this statement. I have found that over and over again, and then the very next visit there would be no discernible neoplasm at all, no inflammation, no sense of resistance, no dullness on percussion, no tenderness hardly, and so it is. Now at the same time, even when the tumor is of considerable size, it may not interfere or encroach very much upon the lumen of the gut: and another curious thing is, that this may be the case when the patient has ill-formed evacuations, when the evacuations, if they be solid, will be decidedly tape-like, as in the case which has just been reported. But there is a complexus of symptoms that is very significant indeed; first, the almost certain steady loss of flesh; secondly, the pain, the mucus and blood; thirdly, the malformation of the excreta, and then, what I consider to be a very important symptom, the tendency to subnormal temperature. I do not think I have ever seen a case of malignant disease of the bowel, and comparatively few cases of malignant disease of other abdominal viscera, where the average temperature was not below the normal figure, excepting those where there is an inflammatory complication of some sort. This is true even where part of the time there is an elevation of temperature. If you strike an average you will find that the greater portion of the time the temperature will be below normal than normal or above, even when part of the time there is a febrile

temperature, and I have been led to place a great deal of importance upon that.

Dr. Mathews: I do not think any one would be justified in saying that there was not a tumor in the sigmoid flexure, simply from the fact that it could be insufflated, as was done by the surgeon who examined the case referred to. As Dr. Ouchterlony has outlined, it is very true that a tumor may embrace the flexure or colon, but the lumen of the vessel is not interfered with in the least. An examination of the pathological specimen before us will prove that this is the case. Therefore an opinion based simply upon the fact (which seems to be the strongest point made by the surgeon in his letter) that by rectal insufflation air can be forced beyond the ileo-cecal valve, to my mind signifies very little if any thing, yet it seems to have been regarded of great moment in the examination of this case.

If then you can not make out a tumor in the sigmoid flexure by the ordinary means of palpation, etc., and if we are misled by such an examination as was made by this surgeon in Chicago, then I would ask, is there any positive means of diagnosing a tumor in the sigmoid flexure? I claim that there is. The importance of making a diagnosis can be easily understood. It is contended by such men as Bull, Lange, and H. Allingham that the sigmoid can be extirpated and removed successfully, as has been done by these three gentlemen for malignant growths. Yet if we state positively there is no malignant growth, and rest upon that diagnosis, then the patient has no chance of his life by that operation.

Now I contend that there is a way or method by which it can be invariably told. That method is the introduction of the hand into the rectum up to the sigmoid flexure and feel it. It does no harm to introduce the hand; it can not possibly result in injury, and therefore, it being a positive method, I claim that under circumstances like this, looking to a proper diagnosis as well as prognosis, in order to give the patient the chance of surgery, that the hand should be introduced where there is a difference of opinion or where it is necessary to make a positive diagnosis of a tumor in the sigmoid flexure.

The essay was read by Dr. P. F. Barbour; subject, Melancholia. [See p. 329.]

DISCUSSION.

Dr. Ouchterlony: I listened with a great deal of interest to the reading of the paper; and as I did so a number of cases that have been

under my care rose up in my memory, and I tried to collate them as well as I could. It seems to me that instead of being a more rare form of insanity melancholia is perhaps the most common form that I have encountered. I do not mean to say that this is the general experience of physicians, but it certainly has been mine. It may be owing to circumstances. As to the etiology, I agree fully with what Dr. Barbour has said. Delusions, in my observation, have occurred more lately in the disease, not very early. Hallucinations are quite common, and continue for a considerable length of time, but as a rule I think it is only after a considerable struggle that they become delusions. A number of cases have recovered under my observation, and yet I am entirely unable to form any idea as to the proportion. I was very much interested in hearing what Dr. Barbour said, and at the same time it is quite distressing to think that the prognosis is so grave. It is a very serious prognosis where only sixty per cent recover, only a little over one half. I did not understand whether it was meant that the disease passed into permanent insanity, or whether sixty per cent terminated fatally. A great many of these cases commit suicide, and the suicidal tendency is quite marked; in some cases I have found the disease to begin suddenly and with manifestations of suicidal tendencies. Of course this may have been owing to the fact that the patient was not subject to intelligent observation. It is very likely that there may have been earlier symptoms that were passed over. The diagnostic points Dr. Barbour mentioned struck me very forcibly. I have not looked particularly for the postnuchal or occipital pain. While I can remember having observed it in some cases, I am unable to say in what proportion; but the diagnostic tripod is a very interesting and important one, for of course the earlier the character of the disease is recognized the better the prospects are for recovery. I have been struck in a number of instances with the fact that not a cause could be found. I remember one case in particular, a man who was well-to-do in every respect. His home life was agreeable; he had friends who appreciated him highly, and every thing seemed to be going on well. All of a sudden one night he did not return, and the next morning when the office where he was employed was entered they were surprised to find tracks of blood in every direction. Finally the man was found in a corner of one of the upper stories, having hacked his wrist with a blunt knife in an effort to sever the radial artery. He had also made incisions at the elbow trying to get at an artery higher up. He had hacked himself in

the lower extremities, and had lost a great deal of blood, and yet fortunately he did not strike an important blood-vessel, and consequently was simply exhausted from loss of blood, without being in a dangerous condition. He felt very much ashamed of himself, and promised that he would never do such a thing any more; but after awhile there was a recurrence, and he tried again to commit suicide. He was always a very quiet man, and it is possible for that reason no one had been able to ascertain his real state of mind, and the disease may have been brewing for a good while, and finally burst forth in this lamentable way. In regard to the treatment, I have nothing to say in addition to what Dr. Barbour has so well said, except to ask the doctor if he has tried the new hypnotic *chloralose*. We all know what our past experience has been in regard to new remedies, what hopes have been kindled by reading about them, and how frequently we have been doomed to disappointment, but really it does seem as if this new hypnotic must have some considerable merit. I am sure I hope so.

Dr. J. A. Larrabee (visiting): Where such interesting discussions are conducted (if two or three are gathered together) you can always count me in. I have not only been entertained, but very much interested by the valuable paper. The subject is one which has interested men in all ages, and not only professional men but laymen and poets as well, and I believe the contribution by Dr. Barbour is a very valuable one, which will not only be recited, but read with a great deal of profit. The paper is not only an interesting, but in some respects a very remarkable one, inasmuch as the essayist has left out what was once considered a great factor in melancholia. Among the ancients it was supposed that melancholia was dependent upon some faulty action of the liver, so-called black bile. I have considered (and I have not given the matter as much thought in the past as I shall since reading Dr. Barbour's paper) the question as to whether melancholia was a disease or a condition. I have looked upon it as a condition which will develop disease by its presence. Melancholic people are usually found to have a hereditary predisposition or possess a peculiar diathesis of this trouble. It is quite rare that we find a person having a sanguine or nervous temperament the subject of melancholia, but it is often encountered in dark complexioned people. Take, for instance, the question of religious insanity. I do not know how many times I have cleared up the most depressed sinners by the administration of calomel and blue mass. I have seen a great many people react under calome

and blue mass, and their morbid ideas have been relieved. I believe that there is a great deal in entertainment also for those who are afflicted with melancholia. We are creatures of entertainment, and if we entertain people continually of one class we will be very much like those whom we entertain. Now man is so constituted that entertainment affects the thoughts, and it is true that if we break up that entertainment early in these cases we can succeed in breaking the chain of the melancholia. It has been many years ago since a large factory in Massachusetts, I believe, toppled over. It was a tremendous structure for those days, being about what the Masonic Temple at Chicago is to our time. Every portion of the building was substantially constructed under the supervision of the best architect obtainable, still without any known cause it one day tumbled down, and a thousand people were killed, maimed, and injured. The cause was never explained until a workman came along and said that he could enlighten them as to why the factory tumbled down. He said "they set the looms all one way." It was then remembered that the looms were on the top floor, and were all set so as to clash at the same time, the consequent shock being greater than any structure on earth could stand. If part of the looms had been set to clash in one direction, and the balance in the other, the catastrophe might have been avoided.

Thus it is by crossing the grain that we are able to break the strain in melancholia. I remember one case where a man would not be convinced that he was not going to die. He believed that he was dying all the time on his feet. A certain doctor was called to see him, and said that if we could just break the chain of thought, and convince the patient, that a cure would be effected. The doctor went in, and taking the patient's hands and then his feet—"Why," he said, "your hands and feet are perfectly warm; do you know that no man ever died with warm feet!" The patient never changed countenance at all, but replied, "Yes, sir, John Rogers, he was burned at the stake." I simply mention this to give you some idea of the persistency of their train of thought, and the difficulty experienced in trying to break it up. If a patient of this character could be taken to minstrel shows, theaters, etc., I think the chain could be broken. I believe that psychical diseases should be treated with psychical remedies. We would not expect to obtain the same results from the administration of drugs that we would in diseases of a pathological nature, and for that reason I have considered melancholia a condition rather than a disease, at least at

first. Another condition which I have found remarkably persistent in those suffering from melancholia is the presence of oxalic acid in the urine, oxaluria, showing a condition or disease which it is possible to relieve. Whether or not the torpid condition of the liver is such as to produce this by the retention of material, is a question which the essayist has left out, entirely ignoring this wonderful organ to which is attributed the majority of cases of melancholia; but I do think in most of these cases we have a condition which can be relieved, and in the relief of which the patient's mind is also relieved. That has been my observation. I am not speaking of cases of melancholia in the asylum, but those encountered in private practice, patients who have to be treated by the ordinary means. I believe then that the principal thing for us to do is to apply such medication as will soften the evacuations, and remedies which will get rid of the metamorphosed tissue, and we will have better results than by resorting to hypnotics and drugs of that class.

Dr. J. F. Barbour: I have often wondered what the pathology could be which is at the bottom of this curious disease we are considering tonight. I remember the instance of an old woman who labored under a severe form of melancholia for five or six months. In this case the melancholia developed very suddenly, probably in the course of twenty-four hours, without any assignable cause. At the end of six months in the same inexplicable way and in about the same period of time the whole trouble disappeared. I believe that the trouble in these cases is purely functional, and those changes which are often found in the nervous system are merely secondary, and are not really the pathology of the disease. Some interesting investigations have been made on this subject by Richardson, of London, and it was probably owing to his experiments that attention was called to the liver as being the seat of melancholia. Richardson noticed what all of us notice to-day, that all diseases occurring below the diaphragm are attended by depression of spirits, that diseases of the thoracic cavity are not attended with this depression. The result of his observations was that he claims to have discovered that the seat of this trouble is the solar plexus, that there is an obstructed flow of blood to the solar plexus and a consequent imperfect nourishment of this ganglion. In regard to relation between diseases of the liver and melancholia, Hammond has taken the view that many cases of melancholia are the result of abscess of the liver, and the aspiration of this abscess or removal by surgery will bring about relief of the melancholia.

Dr. T. P. Satterwhite: I believe that one cause of the large per cent of non-recoveries in all diseases of the character under discussion is that the patients are retained at home too long. In all forms of mental disease too much valuable time is lost in separating the patients from home surroundings and putting them under proper treatment; this includes, as Dr. Barbour has said, systematic feeding. There is not so much value to be attached to the medication as in the feeding in the management of these cases. I saw, a year or more ago when I was East, a very remarkable case of melancholia in which the patient determined to commit suicide if possible by means of starvation. It was in one of the State institutions that I saw the case, and the patient had been maintained for three years by stomach feeding through a tube. She was in a fair state of nourishment at that time.

Dr. J. M. Krim: I fully agree with Dr. Satterwhite that patients suffering from mental disease should be gotten away from home as soon as possible. I had a case of this kind about three months ago in a lady sixty-six years of age, her husband being seventy-four. Her melancholia or mental disturbance was principally that she was suspicious that her husband left home in the early morning and did not return until late in the evening. While she was treated at home there was no apparent improvement in her condition, no form of medication or management seemed to have any effect. She was removed to an asylum about two months ago, and I understand there is already a marked improvement. I simply mention this to emphasize the belief that the best results in the treatment of these cases can be obtained by their early removal to a proper asylum.

Dr. Larrabee: Do you not think in these cases if the patient is told the trouble comes from abscess of the liver, and if pus from any other source is shown him after the operation, that his melancholia will be greatly improved?

Dr. Ouchterlony: I am afraid that cases of melancholia are not so easily cured as that.

Dr. Irwin: The theory advanced by Richardson regarding obstructed circulation through the solar plexus is a rather delicate one, but not so much as the theory advanced by Hammond that the trouble is invariably due to abscess of the liver. Other theories attaching the responsibility to various organs below the diaphragm have had their advocates from time to time.

Within the last two months it has been my privilege to attend in

this city two men who have had acute melancholia. The attacks came on in both cases very suddenly. There was no evidence of disease in the region of the liver in either case. There was nothing I could discover that could interfere with the circulation through the solar plexus. I found that mental trouble was the cause of the melancholia in both cases; both of the men happened to have their money locked up in one of the National banks here which suspended. They were about to lose every thing that they had accumulated. Both were stockholders in the bank referred to, and one of them owned stock in another bank which had also suspended, and both suffered from acute melancholia. How the locking up of their resources in the National bank and the fear of losing every thing could have interfered with the circulation of the blood through the solar plexus or brought about an abscess of the liver in each case so suddenly, are questions that I have been unable to solve. I simply refer to the point that if the circulation through the solar plexus was obstructed in these cases, the cause was peculiar; if the liver took on an abscess in these cases, the cause was equally peculiar. Therefore I am inclined to the belief that both of those theories are very mythical. The first case that came under my observation is still under my treatment, and the patient is not well; his money is still locked up. He suffers with the delusions of melancholia to-day, but the symptoms are not quite so severe as when he was first taken. The other case has left the scene of action. I was called away from the city while attending the second case, and as I had an excellent consulting physician and surgeon I advised that he be called to see the case in my absence. We had given this patient, who was suffering from an acute attack of melancholia, hypnotics which caused profound sleep and brought about some amelioration of his condition, but one morning he arose from his bed and committed suicide by walking off a moving train.

I have seen a good many cases of true melancholia, not the ordinary disturbances which we see arising from engorged circulation, diseases of the liver, and organs below the diaphragm, diseases that are often relieved by treatment—I speak now of true melancholia. I do not know what causes it. It is due to some altered condition of the intellectual apparatus of man. That is about as far as I can go. So far as any pathological condition is concerned I do not know any thing about it. I have never seen any case of true melancholia to fully recover. I have seen them get some relief, and apparently at times they looked

as though they were well. So far as other disturbances are concerned, simulating melancholia and dependent upon to some extent the digestion, assimilation, etc., these cases when properly treated, when taken away from home surroundings, given a change of scenery, change of air, etc., and when they are brought in contact with strong minds which are able to convince them that they are not going to die, they sometimes get well or nearly so; but I question even in these cases if complete cures ever result.

Dr. Barbour: I would like, in closing, to say a few words in regard to one or two points that have been brought out in the discussion. I think the good accomplished by removing patients suffering from melancholia from their homes and home surroundings, which has been emphasized so much, is simply owing to the tonic effect of change of scenery, change of air, etc. It has very little effect upon the mind. You can talk to a melancholiac, or a patient with any other form of insanity, and you are talking against the wind. You can not convince them by any process of reasoning that you are right. When patients are getting better you can often convince them of their delusions or hallucinations, and when the patient gets to the point that he knows that he has hallucinations he is almost well. I regard traveling as simply a tonic treatment, and as producing its good results by its effect upon the general system of the patient and not by producing new mental impressions.

Regarding oxalic acid in the urine of these patients, I think this is another form or another instance of indigestion or dyspeptic trouble, and believe that proper treatment of the digestive apparatus of these patients is the only thing we need do for their relief. We do not know what is the essential lesion of the patient, we only observe certain symptoms he has. There is no pathology to true melancholia; we are not able to tell from a *post-mortem* of the brain that the patient has had melancholia. So that systematic feeding and proper treatment of the digestive system is one of the few things that we can get hold of to treat.

I do not agree with Dr. Larrabee that hypnotics are of secondary importance in the treatment of these cases, although I do believe that too much importance is often laid upon hypnotics in the treatment of insanity. We have to give these patients rest and sleep, otherwise the increased activity of the brain is sufficient of itself to wear them out.

T. C. EVANS, M. D., *Secretary.*

Foreign Correspondence.

LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

The Opium Commission; Milk as Food; Mr. Bruce Clarke on the Use of Izal; A New Exhibition; Dr. Ellis on "Running Amock;" Death of Dr. Parke.

The Opium Commission have just held their last sitting for the purpose of taking evidence. Dr. William Lockhart, who has been for twenty-five years a medical missionary in China, said the victims of the opium habit, who were comparable to our drunkards, were not allowed to give evidence in the Chinese courts of law. Alcohol was a much greater social evil than opium. Opium did not provoke a tendency to suicide; though, being the pleasantest way of getting rid of life, it was very often used for that purpose, especially by women who had quarreled with their mothers-in-law and wished to make the latter chargeable with their deaths. Indian opium was not forced upon the Chinese; it was purchased in the same way as Manchester goods and other articles of commerce. He thought, however, that the British Government ought not to engage in the trade. Deputy Surgeon-General Partridge, of the Bombay Army, complained that we were sending enough opium to China to poison 19,609,000,000 of people; but a member of the Commission said that calculation could hardly have much value, for we were credited with eating enough salt in the year to kill ourselves twelve times over if we only took a pound of it at a time.

A strong plea for the increased use of milk and its products as food is put forward by Dr. Bond. According to Professor Huxley, he says an adult person of average weight under ordinary conditions loses in twenty-four hours 6 pounds of water, 4,000 grains of carbon, 300 grains of nitrogen, and about 300 grains of mineral matter mainly consisting of phosphates. Now Dr. Bond points out that three and a half pints of new milk contain about 6 pounds of water, 4,200 grains of carbon, 308 grains of nitrogen, and nearly 308 grains of mineral matter which is chiefly made up of phosphates. Thus, he adds, it is clearly possible for a man of average weight (154 pounds) to keep himself in good condition by the daily consumption of about half a gallon of milk alone; and less of course is needed when bread or other farinaceous food is eaten with the milk. The excessive consumption of meat leads to gout; but what medical man, Dr. Bond asks, ever had to prescribe for a case which could be attributed to the overconsumption of milk?

Last year Dr. Klein drew Mr. Bruce Clarke's attention to a new substance called "izal," which exhibited very remarkable disinfectant properties, and had the advantage of being non-poisonous even in a highly con-

centrated form where the higher animals were concerned. It was also non-irritant. Izal is a by-product obtained in the process of coke formation. Mr. Clarke determined to try its efficiency and its applicability as a surgical disinfectant, and up to the present time has used it in his surgical work at St. Bartholomew's Hospital for upward of eight months with the happiest results. Mr. Clarke keeps the fluid diluted down to a strength of 1 in 50 in bottles ready for use, the subsequent dilution to 1 in 200 being effected at the actual time of operation. The sponges which are used in an operation are cleansed, according to his usual custom, in soda and water, and then rinsed several times in fresh water until they no longer cause any turbidity in it. After this they are placed in a jar of izal (1 in 200), and kept there for at least twenty-four hours before use. The gauze employed as a dressing is the ordinary gauze of commerce, boiled for twenty minutes in a saucepan over a fire, and then soaked for twenty-four hours in a solution of izal (1 in 200) like the sponges. The gauze he uses is wrung out just before use and placed moist over the wound without the intervention of any protective between it and the wound. A sufficient number of layers are used to allow for soakage, the outside being covered with cotton wool to prevent the bedclothes from being wetted. The instruments are immersed in the same fluid for a quarter of an hour, and the hands disinfected in the usual manner. Mr. Bruce Clarke has used the fluid in fresh operation wounds, in cases demanding special purification, as ulcers, etc., in which skin grafting in Thiersch's method was employed in abscesses and sinuses of varying degrees of complexity, all of which were septic to start with. He has also used it in sinuses in connection with mucous membranes, including fistulæ in communication with the urethra, and a case of prostatic abscess opening both into the rectum and bladder. It is found to invariably prove of the greatest benefit in its effect on mucous membranes, and can readily be used in inflammation of the mouth, nose, and throat, where a poisonous substance like corrosive sublimate is quite inadmissible. Mr. Bruce Clarke feels sure that an antiseptic has been found which is easy to use, does not irritate one's hands or the patient's skin, and is at the same time the most powerful disinfectant with which Dr. Klein or he is yet acquainted.

Active steps are in progress for holding next year an Exhibition at the West End, the net profits of which are to be distributed among the London hospitals. Already the guarantee fund which has been started has received very encouraging support. The Exhibition will be divided into three sections, a Professional Section, a Loan Collection, and a Trade Section. The first section will be reserved for exhibitors professionally connected with or interested in ambulance work, calisthenics, dentistry, hygiene, medicine, nursing, philanthropy, and surgery. There will also be a Naval and Military Section, in which will be demonstrated the method of treating the wounded in active service. In the Loan Collection a large gallery will be provided, in which will be illustrated the history, organization, and development of London hospitals. It is intended that this section shall be

managed by a committee nominated by and representing the London hospitals.

Dr. Ellis, the Medical Superintendent of the Lunatic Asylum at Singapore, discusses the peculiar form of madness which causes the individual to "run amock." In his last report he shows that fright, grief, brooding over real or imaginary wrongs, the sight of blood (especially the patient's own blood), and a peculiar state of nervous depression have been noted as the exciting causes. The question is, how far can a man be held responsible for his actions when in this state? There is intense muscular spasm and unconscious paroxysm of homicidal mania. During the paroxysm the affected individual will rush through the most crowded streets, stabbing right and left at all coming in his way. After such an outbreak, the duration of which may be from a few hours only to a few days, the patient can not remember any thing that took place during the attack. His usual explanation is that his head was giddy and that all subjects appeared red or black. Dr. Ellis finds that all men examined from a day to a few weeks after the incident had a wild, furtive stare, and when questioned on the subject their breathing became hurried and their pulse quickened as they replied, "I don't know" or "I don't remember." In some cases the mania comes on suddenly, in others the patients work themselves up into a state of uncontrollable rage after some real or imaginary wrong.

The sudden death of Surgeon-Major Thomas H. Parke while on a visit caused great and widespread consternation. Dr. Parke was an Irishman, and was attached to the expedition for the relief of General Gordon in 1882, and he is better known as having accompanied Mr. H. M. Stanley upon his expedition for the discovery and relief of Emin Pacha. Dr. Parke had received many honors both at home and abroad, except from the British Government. He was buried in Dublin, with full military honors, in presence of an immense concourse of spectators.

LONDON, September, 1893.

DERMATOL.—Matheus (*Therap. Monatsh.*, August, 1893,) has used dermatol with great success in the treatment of ulcers, etc., but in its application to these troublesome affections in the lower extremities its use was often accompanied by the appearance of a localized dermatitis, affecting the skin for some distance around the ulcer, causing much redness and troublesome serous exudation. This took place after an external use of dermatol, and during perfect rest after about a week's treatment, the affection lasting ten to fourteen days, and in one case giving rise to much pain and urticaria. The author gives the histories of three patients where this complication occurred, but the ultimate recovery of the ulcers was by no means impeded, as healing took place in from three to five weeks.—*British Medical Journal*.

Pediatrics.

In Charge of Henry E. Tuley, M. D.

TREATMENT OF CHOREA.—Eskridge (*Philadelphia Medical News*, Vol. lxiii, No. 14.) The medicinal treatment advocated is as follows: the patient receives as many grains of antipyrine as he is years old, and the dose is increased one grain each night until all twitching stops. At the beginning of the treatment of mild cases one drop of Fowler's solution is given after each meal, and the dose increased one drop each day until the point of tolerance is reached; then the arsenic is discontinued for two or three days, or until all unpleasant effects have passed away, when the drug is again resumed at the dose reached when it was stopped. The dose is again increased one drop each day until tolerance is reached, when it is discontinued, and resumed after two or three days as before. As soon as the twitching ceases the antipyrine at bedtime is discontinued, and the patient given the syrup of the iodide of iron in from three to ten-drop doses, depending on the age of the patient. The arsenic and the iron are continued for two or three weeks after all symptoms of the disease have disappeared and the patient has regained considerable flesh.

In all but the mildest cases absolute rest in bed day and night is insisted on from the first. In the severe cases the same treatment is employed, except the arsenic is not begun until the twitchings have stopped from administration of the antipyrine, and after the second or third day of the arsenic administration the antipyrine is given only once in each twenty-four hours, and the time for its administration is between eight and nine o'clock in the evening.

The precautions necessary in the giving of antipyrine are, to be withheld in cases where there is much rise of temperature, when there is cardiac weakness, and in cardiac dilatation, and never give it unless patient is in bed.

As a rule, children bear larger doses of arsenic than adults, and its administration is not followed by ill effects if given as indicated above, stopping until all unpleasant effects have passed away. As a rule, it should be given for a month or more after all choreic symptoms have ceased.

CONGENITAL MALFORMATION OF HEART.—At the Obstetrical Society of Edinburgh, Dr. James Carmichael showed the heart of a child with congenital malformation. The heart in the recent state exhibited the following appearances: It was of a dark red color. The right ventricle was much enlarged, forming most of the apex of the organ. The appendix of the left auricle projected unusually far forward in front of the pulmonary artery. The pulmonary artery was dilated. The pulmonary valve was normal; the conus arteriosus beneath showed remarkable hypertrophy. The aorta was some-

what large in its ascending portion, the innominate and left carotid coming off within one eighth of an inch of each other, one quarter of an inch further on another minute branch, and one eighth of an inch further still the left subclavian. Beyond the subclavian the aorta took a sharp V-shaped bend downward, and into the apex of the V a patent ductus arteriosus entered. Beyond the second limb of the V the aorta appeared of normal diameter. The left auricle was dilated. Its cavity would have held a bantam's egg. The pulmonary veins ended within the lung, the auricular cavity having extended back to the lung. The foramen ovale was closed. The walls of the left ventricle were thickened, the cavity being slightly less than normal in size. The mitral orifice was almost completely stenosed, the chordæ tendineæ and valve segments being so fused together as to leave only three minute orifices big enough to allow the passage of a probe, the only passages for the blood to flow through. The aortic valve appeared normal. The right ventricle was much hypertrophied, and the cavity dilated. The tricuspid valve was normal. Intraventricular septum quite closed. Right auricle dilated, but its walls not thickened. The child was a girl three years old. Clinically she presented a typical picture of cyanosis. The history showed that at birth the child appeared to be healthy, and passed through the lactating period without any ailment. When about a year old she began occasionally to suffer from fits of dyspnea. On examination of the heart the precordia showed some bulging; the apex beat was in the fifth interspace, just internal to the vertical line of the nipple. Percussion showed a normal area of dullness. On auscultation the sounds were loud and distinct, following one another with more than usual rapidity, the long pause being correspondingly lengthened. No murmur was at any time audible. There was marked reduplication of both sounds in all the areas. The pulse was abnormally frequent, generally about 100, and somewhat irregular; the radial, posterior tibial, and brachial pulses were imperceptible; those of the larger arteries could be made out with sufficient distinctness.—*Obstetrical Society of Edinburgh.*

OVARIAN TUMOR WEIGHING ONE HUNDRED AND ELEVEN POUNDS REMOVED FROM A CHILD OF FIFTEEN, WHOSE WEIGHT WAS SIXTY-EIGHT POUNDS.—Dr. W. W. Keen, of Philadelphia, reports a case of the above description. Before operation the tumor had been tapped four times and three or four gallons of fluid removed each time. From the ensiform to the umbilicus the measurements were sixteen and a half inches, from ensiform to pubes twenty-nine and a half inches, circumference forty-nine inches. Through a primary incision the tumor was tapped and eighty-four pounds of fluid removed: incision enlarged till it measured eight inches. An enormous ovarian cyst was found, a number of moderate adhesions, the viscera being entirely free. The pedicle was but two and a half inches broad, the tumor arising from the right ovary, the left ovary being small but healthy. The solid mass removed weighed twenty-seven pounds, mak-

ing the total weight of tumor and contents one hundred and eleven pounds, the child weighing but sixty-eight pounds. Glass drainage, which was removed on fifth day, was replaced by a rubber one when the discharge recommenced. At end of two weeks she sat up, and when report was made child was remaining in hospital because of the slight discharge from the drainage opening.—*Texas Medical Journal.*

A CLINICAL STUDY OF PERTUSSIS.—Dr. E. Helen Knight, in New York Medical Journal, records the results of examinations made in forty cases of pertussis with special reference to the heart and circulation. An effort was made to discover not only the nature of the strain during the paroxysms, but also whether such strain persisted in the intervals of the paroxysms. The phenomena exhibited by inspection and palpation were that the action of the heart was in many cases irregular in rhythm and also in force during the spasms, and in many cases irregularity was present in the intervals and until the following spasm occurred. The length of time taken for the heart to regain itself varied from about ten seconds to several minutes. The action of the heart was rapid in all cases, in some disproportionate to the respiration.

Temperature Elevations. In fifteen per cent of the cases it was above normal without abnormal lung signs, in one case as high as 101.2° axillary.

Condition of the Urine. Urine was studied in twenty cases. Number of examinations made, eighty-six. Reaction acid in all but two examinations. Specific gravity 1020 average. Albumen and sugar were present each sixty-six times, blood twenty-four times, hyaline and epithelial casts in two examinations.

Treatment. In all cases antipyrine was administered from the time the children were first seen. In all cases where heart strain was manifest during the intervals digitalis was added to the antipyrine. Antipyrine was given in doses of one grain for every year; maximum dose, five grains. Tincture of digitalis, one minim for every year; maximum dose four minims.

TREATMENT OF INFANTILE CONVULSIONS.—M. Jules Simon advises the following method: (1) Relieve the digestive organs by a laxative or by tickling the throat until vomiting occurs; (2) if the attack continues, give ether or chloroform by inhalation; (3) administer within twenty-four hours the following antispasmodic mixture:

| | | | |
|---------------------------|---|--------------|-----------|
| Chloral hydrate, | } | āā | gm. 1; |
| Bromide of potash, | | | |
| Syrup of codeine, | } | āā | gtts. 10; |
| Tincture of musk, | | | |
| Tincture of aconite root, | | | |
| Orange flower water, | | | gm. 100. |

(4) if the attack is grave and prolonged, place the patient in a warm bath, and apply, with suitable antiseptic precautions, a small blister to the back

of the neck or to the epigastrium, leaving it in place not longer than three hours. As soon as vesication is established, substitute a poultice for the blister.—*Union Medicale*, June 1, 1893; *Occidental Medical Times*.

TREATMENT OF SCARLET FEVER.—Bartlett (in Buffalo Medical Journal) upon the treatment of scarlet fever concludes as follows: (1) The hygienic directions in preparing the sick-room; (2) the local cutaneous treatment by dry mustard frictions, followed by bichloride sponging, later by sodii carb. bath and oil inunctions; (3) the breast pad, medicated as described; (4) enteroclysis, with solutions hydrarg. bichloride 1 to 8,000 or 16,000, varying with the age of the patient; (5) the hygienic essentials as formulated by Drs. Baker and Wende and boards of health generally; (6) the moral obligations imposed upon the physician, far too frequently ignored, to be faithful to his trust in every detail, upon the intelligent discharge of which such important interests depend.

EMULSION OF COD-LIVER OIL.—The following note upon cod-liver oil is made by Dr. J. Madison Taylor in the Philadelphia Polyclinic: "The best form is a cold pressed oil from freshly selected livers. The difference between this and inferior oils, both in taste and efficiency, can not be overstated. This kind can always be given straight. I devised a very economical and handy form of emulsion which my assistants use much. In an eight-ounce bottle six ounces of oil are put, the mother adds to this one raw egg, one tablespoonful of whisky, and fills the bottle up with glycerin. The whole is then thoroughly shaken and kept in a cool, dark place. It is agreeable and well retained.

CHANCRE OF THE TONGUE IN A CHILD.—Dr. Everett Russell, in Medical Brief, reports a case of this description. Boy, five years old, was brought to clinic for what was supposed to be a boil on his tongue. Examination showed a chancre in the center of his tongue, typical in appearance, hard, indurated base, and clean cut edges. A well-marked syphilitic roseola was present on his back. Infection occurred in all likelihood from a male cousin aged nineteen years who had some "private" trouble, and with whom the boy was sleeping. The roseola and chancre gradually disappeared under inunctions of oleate of mercury and saturated solution of potassium iodide

GYMNASTIC TREATMENT OF THE FEEBLE-MINDED.—Dr. Gulick contributes an article on this subject to Physical Education for June, and teaches how, through the connection of exercise of muscle, it is possible to exercise and thus develop those parts of the brain that have to do with muscular contraction, and that thus, as well as in other ways described, the brain can be stimulated to develop.

Abstracts and Selections.

THE ROLE OF THE POSTERIOR URETHRA IN CHRONIC URETHRITIS.—In a paper read by Dr. Bransford Lewis, of St. Louis, before the June meeting of the American Association of Genito-Urinary Surgeons (Medical Record, June 29, 1893), the author presents some very radical and unorthodox views on the frequency of posterior urethritis and its influence in the production of chronic gonorrheas.

The various causes commonly accepted as sufficing to explain persistence in gonorrhea were reviewed, and their potency as such was denied *seriatim*. Two cases were reported showing that the presence or absence of the gonococcus alone could not form a reliable criterion as to prognosis: Case 1 (primary), with abundant gonococci, containing discharge, lasted six weeks; while Case 2 (secondary), also giving abundant gonococci, containing discharge, lasted only one week. The influence of anatomical abnormalities was restricted to only a small minority of the exceedingly numerous cases of chronic gonorrhea, and did not explain the great number that occurred. The several varieties of urethritis, such as "granular urethritis," "catarrhal urethritis," "hypertrophic urethritis," etc., were only pathological incidents, not causes of chronic gonorrhea; and even on discriminating between these several varieties the question still obtruded itself: What was it that had produced that particular variety?

Again, urethral therapists, with ardently advocated new remedies, supposably specifics, had all in turn failed in their endeavors to abolish prolonged claps. So that it must be acknowledged that the various factors to which chronic urethritis was usually attributed, while relatively important in a contributory way, did not cover the ground in actual clinical experience, and something else must be found to bear the onus of being a prolific source of chronic gonorrhea.

While aware that infection of the posterior urethra was almost universally recognized by advanced practitioners of the present day as a complication of gonorrhea that was difficult to cure when it did occur, that interfered with the usual course of treatment employed, and required special measures for its relief, etc., he did not believe that the full importance of posterior inflammation was generally conceived, that its frequency was even approximately estimated in general, or that its bearing on almost every case of gonorrhea was understood, recognized, or acknowledged.

In Dr. Lewis' opinion the posterior infection should not be looked upon as a complication, but as a natural feature, occurring with such unfailing regularity that an observer, watching carefully and critically gonorrheal cases, must see a great many of them before he would meet with a single

one that remained free from the so-called complication throughout the disease. This conclusion, to which clinical investigation had led him, was supported, in recent writings, by the following statistics of authors who had been pursuing a similar study of late years: Lesser asserted that of fifty-three cases of primary gonorrhea under his care, the posterior urethra escaped infection in only four cases, making the frequency of posterior urethritis 93.5 per cent. Jadassohn found posterior urethritis in 143 of 163 cases, making 87.7 per cent; Rona found it in 79.7 per cent of his cases; and Eraud found it in 80 per cent of all of his cases.

In endeavoring to harmonize this undoubted fact of frequency of posterior urethritis with the reason for its frequency the author disregarded, as inapplicable, explanations usually given. Sexual intercourse, the "forced" injection, the passage of instruments, etc., during an active gonorrhea, were chiefly complained of by writers on the subject—extremely seldom by the patients themselves. Bearing on this point, the time and mode of onset of the posterior inflammation was of importance. Instead of the inflammation progressing slowly and gradually backward over the urethral mucous membrane and reaching the posterior urethra in the second or third week, as was commonly taught, it reached the posterior urethra, in most cases, in the first (active) week of the disease. This rather favored the supposition of Horteloup that the mode of infection was through the lymphatics rather than by continuity over the mucous surface.

The author, therefore, felt justified in submitting the following conclusions:

1. The causes usually given for the prolongation of cases of clap (presence or absence of gonococci, stricture of large caliber, the use of particular drugs in treatment, etc.) do not satisfactorily explain them, nor do they furnish reliable means for prognosticating the outcome of a case.
2. A single widely prevalent cause for such prolongation of gonorrhea has, as yet, not proved its right to recognition as such.
3. Posterior urethritis, by reason of its anatomical seclusion and inaccessibility to ordinarily prescribed treatment, if frequent, offers the best explanation for such prolongation or repeated recurrence.
4. Scrutinizing clinical investigation shows posterior urethritis to be present in the great majority of cases of prolonged or severe gonorrhea.
5. Direct topical treatment to the posterior urethra is, therefore, necessary in the great majority of cases.
6. The causes usually given for producing posterior urethritis are not commonly found to be real factors in the clinic.
7. The mode of onset usually described does not coincide with that discerned in clinical observations.
8. These two latter observations confirm the probability that the posterior urethral infection is accomplished through the lymphatics, and explain the frequency of such infection.
9. Posterior urethritis is not a complication, but a natural phenomenon of gonorrhea.

LONG-CONTINUED BLADDER DRAINAGE.—(American Society of Genito-Urinary Surgeons.) Dr. Paul Thorndike, of Boston, read a paper on this subject. He stated that the employment of absolute rest has long been recognized as an essential in the treatment of most forms of inflammation which affects the genito-urinary organs, and especially the bladder, it being a comparatively common procedure to drain the latter organ for a few days, either through the urethra or perineum, in order to obtain for it as complete a rest as possible under certain conditions. The long continuance of such drainage is less often carried out.

There are unquestionably cases of prostatic and vesical disease of obstructive origin, when the condition of the bladder demands drainage as a means of relief. In this way is provided rest from the bladder's irritable contractions, and also from the pain and discomfort which catheterization, frequently repeated for long periods of time, almost inevitably induces. Such cases are common enough, and the relief obtained by proper drainage is prompt and sufficient.

Drainage may be afforded through a catheter tied into the bladder and removed only to be cleaned; or through a perineal wound, with or without a drainage-tube. In many cases the catheter drainage answers every purpose; in others, the perineal outlet is preferable, because the operation is rendered necessary for diagnostic or therapeutic purposes, aside from the question of drainage, or because the mental condition of the patient is such as to render it very difficult to keep a catheter of any sort in his urethra.

The author stated that it is his belief that perineal drainage is a more effective way of keeping the bladder empty than draining through the urethra can be, and it should be the method chosen if the conditions are such as to warrant its use.

That these methods of drainage may often be continued for a long time with the greatest advantage to the patient is unquestionably true, and that a permanent drainage of the bladder adds many years of comparative comfort to many lives is doubtless also true.

Dr. Thorndike then gave the histories of three cases coming under his care in which he practiced long-continued drainage with very good results. The first was a case of obstructive prostatic hypertrophy in which a soft rubber catheter was passed into the bladder through the urethra, tied there, and allowed to remain for three weeks. In the second case, also one of prostatic hypertrophy, the catheter was passed in through a perineal opening, and kept there for two and a half months. In the third case, one presenting prostatic and bladder symptoms of long standing, complete recovery followed drainage through a perineal opening continued for two months.

Long-continued bladder drainage has also been employed with advantage in certain cases of suppurative pyelitis, where the inflammation is of tubercular origin, or due to an extension upward of a purulent process or to other causes, chief among which are the cases due to crystalline elements in the urine. The advisability of operating upon the tuberculous cases is doubt-

ful, still the field is large enough to make a consideration of this method of treatment a very interesting one.

In conclusion, Dr. Thorndike states that long-continued vesical drainage is undoubtedly of value in some cases: among these may be mentioned:

1. Some cases of vesical and prostatic disease, where the operation is done to palliate symptoms, where a radical operation is inadvisable or impossible.
2. Some cases of suppurating pyelitis not of calculus origin. Most tubercular cases are probably outside the field of this treatment. Here the drainage can be tried as a palliative measure before resorting to severer ones, such as nephrotomy.
3. Some cases of obstinate urinary fistulæ.
4. An occasional chronic urethritis.
5. Cases of chronic cystitis due to disease of the spinal cord.

THE IDENTITY OF THE STREPTOCOCCUS PYOGENES AND THE STREPTOCOCCUS OF ERYSIPELAS.—The morphologic resemblance between the pyogenic streptococci and the streptococci of erysipelas early suggested the possibility of their identity, but it was difficult to furnish the proof to substantiate such a belief. A case recently reported by Knorr (*Berliner klinische Wochenschrift*, 1893, No. 29, p. 699), of Berlin, would seem to furnish the necessary demonstration. The case was one in which in the sequence of an injury to the foot an abscess developed upon the thigh, and in the contents of which pyogenic streptococci were found. At a later date an area of erysipelas developed in the sacral region at the site of a small bed sore. The case terminated fatally, and after death examination of a bit of skin removed with suitable precautions from the erysipelatous area disclosed the presence of streptococci that both in appearance and in behavior in cultures and upon inoculation were identical with those obtained from the abscess, while similar organisms could not be found in the healthy skin.—*Medical News*.

PHENOSALYL.—This is a mixture of phenol, salicylic and lactic acids. It is prepared by mixing them together at a temperature of 140° C., at which point they unite. Menthol and eucalyptol are then added, and after cooling the whole is mixed with four times its bulk of glycerine. Such, according to Dulerly (*Therap. Blätter*, No. 5, 1893), is the composition of phenosalyl. As an antiseptic, the author has compared its action with others, and considers it in this respect satisfactory. Comparing it with phenol, sulphate of copper, and sublimate, with regard to any toxic action, it was found to be comparatively non-poisonous, even when injected into the peritoneum or directly into a blood-vessel; but this may well be, as its antiseptic powers are less evident than those of any of the substances with which it is compared. The author has used it with success in a variety of uterine disorders, in gonorrhea, and as a wash for rectal sores.—*British Medical Journal*.

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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THE HOMICIDAL MONOMANIAC.

The assassination of the Mayor of Chicago by a crank, at the conclusion of the most gigantic and successful exposition of the scientific, industrial, and mechanical triumphs of the age, again calls the attention of the world to the dangers to society from the crank element in our civilization. When we contemplate the deed we are tempted to regret that the cruel law of the semi-civilized Chinese, which strangles all the insane, might not be mitigated and modified to suit this particular class of cases.

The medico-legal farce of a trial by jury enacted in the case of Guiteau for the killing of President Garfield will probably be repeated in this case. The complex machinery of the law in such cases requires that an unprejudiced jury shall be impaneled, while an army of scientific medical experts must be summoned who will swear that at the moment the deed was committed the malefactor was perfectly sane.

While it may be expedient to inflict the death penalty in these cases, the necessary procedure is a technical makeshift unworthy of science and of the law. Can twelve men of common sense be found among Chicago's many thousands who could be unprejudiced in this case; or can competent experts in mental diseases be found who can say without stultification that the self-confessed murderer was perfectly sane when he committed the deed?

Common law declares that the insane and the imbecile shall not be held accountable for their acts; that they shall be restrained and segregated, and receive the commiseration of their fellows, being treated as unfortunates, not as criminals.

The danger to society from the crank element is manifest; and, "more's the pity," it is the best men who are singled out for inglorious death. That society shall take some effective means of protecting those whose prominence in public life makes them ready targets for the crazy murderer's pistol is imperative, since there is no safety to our public men if those who have this mania be not made to know that their threats or attempts at murder will be followed by speedy, certain, and adequate punishment.

If there had been a law in Illinois whose execution would have put the murderous monomaniac who threatens the life of any man where it would be ever after impossible for him to carry out his threat, the threats of Prendergast would have had legal attention in good time, and Carter Harrison's useful life would have been spared for greater usefulness.

This suggestion of punishment may seem unduly severe in this philanthropic age; but the solemn experience of almost every community in the land bespeaks for it the favorable consideration of our law-makers. If, however, the crank who threatens life may be turned loose to carry out his threat, with no more restraint than a bond to keep the peace, there seems to be no question that society should dispense for good and all with the services of the murderous monomaniac who succeeds in killing somebody; but why should he be given the temporary notoriety of a public trial and execution? In justice he can not be turned over to the executioner if he were insane when he did the deed; and to contend that he was sane when he made the fatal thrust or shot is to talk without scientific warrant and make medical expert testimony a pander, through expediency, to a travesty of justice. Moreover, the condemned insane criminal may, as Guiteau did, assume the air of a hero, and, standing on the scaffold with the pose of a martyr, suggest to his fellow cranks a further incentive to tragic crime.

An economic remedy for this would seem to be some wise special legislation in the interest of the public against the homicidal crank. Many means may suggest themselves to those who are skilled in legal matters; but a good one appears to be the appointment of a commission, made up of judges, jurists, and experts in alienism, who shall have power to dispose of the culprit in such manner as may seem to them best for the public good. It is doubtful if he should ever be put to death; but there can be no question that he should be put where he can never again be a menace to society.

Notes and Queries.

THE PROGRESS OF CREMATION.—Cremation is like an epicure's dish, which must be tasted often before it can be liked, and the first taste thereof requires fortitude and high thinking. Cremation has been opposed quite needlessly as a violation of law, of custom, of religion, etc. It deserves none of these censures, however, and is unmistakably growing into favor in Europe and America. In Germany (Prussia is an exception), for instance, in populous countries in particular, it is more frequently practiced than elsewhere, perhaps from necessity. In Gotha alone during the past fifteen years there have been nearly twelve hundred cremations. It is found to be a decent, honorable, and salubrious method of disposing of the dead. It is easy and not expensive. Nor is this all. The usages of the churches, the rites that make up a Christian's obsequies, are not neglected. The burial service is commonly read; and we can scarcely resist the evidence that in the eyes of the Church there can be nothing impious in this mode of sepulture.

We are indebted to Mr. Aubrey Richardson for the ability to make these statements with a clear conscience. In an excellent little book recently published, entitled the *Law of Cremation*, he gives ample proof of what has just been said. What can be more satisfactory than the following passage describing the method of procedure at Gotha: "The crematorium, constructed after the design of Herr Siemens, Engineer, of Dresden (regenerative system with gas-furnace), stands in the new cemetery at Gotha. All the apparatus is situated underground, beneath the chapel floor, and is so arranged that the coffins can be lowered gradually into the receiving-chamber during the reading of the burial service, and mechanically passed on into the furnace itself." Such obsequies are not unpleasing, and we hardly think that any imagination will startle at these details.

The selection of the site of a crematory is a point of the utmost consequence to the public. For, although the combustion of a corpse may be accomplished in a rapid, inoffensive manner, as far as disagreeable sights and smells are concerned, yet this would not always be so if no proper rules were formulated and observed in so important a matter; and the proximity of a crematory can hardly be contemplated with any other feeling than aversion. The sixty-fifth article of the Italian Burial Law, which directs that "crematory furnaces must not be erected without the walls of public cemeteries," is wisely followed by the law or custom of most countries.

What are the objections to cremation as a form of burial? We consider the reasons against it rather than the reasons for it, because the latter are too obvious to need discussion. The chief objection is that mankind in

Christian countries has for centuries preferred to bury its dead. Constantine strongly condemned the practice of cremation on religious grounds. Napoleon rejected it after mature deliberation. The fact that men have a prejudice in favor of burial, a prejudice to which they adhere to with passionate hereditary instinct, is a positive objection to cremation. A scruple regarded as pious and honorable is no light thing. Men who are under the influence of this scruple will always find in cremation something unspeakably revolting, some taint as of impropriety or barbarism, some want of respect for the dead and for the religious feelings of the living. The practice, they will say, has been more frequent with barbarous than with civilized races. The savage and superstitious Carthaginians adopted it. It was an immemorial custom with the North American Indians; so, too, with the Druids. The great races of antiquity condemned it. The Jews and Egyptians practiced it not at all; the Greeks but seldom.

Such prejudices, indeed are wholly groundless. Yet, as long as public sentiment is of this mind, cremation can not be popular, can not certainly be enforced by law.

The objections so frequently urged against cremation, its difficulty and expense, can scarcely be maintained now. In fact, the practice is not more difficult and more expensive than ordinary burial. The United States Cremation Company (limited), whose regulations deserve to be carefully studied, requires but an advance of \$35 for this purpose. A more important objection is that cremation may offer opportunities of destroying the evidence of crime. This objection, we are convinced, betrays a complete ignorance of the legal procedure of cremation. For the law on this subject, the police regulations that every one must observe where cremation is legally recognized are much more efficient safeguards against crime and the concealment of crime than the regulations of ordinary burials. In England, where the practice of cremation is merely tolerated as not illegal, an enormous number of persons are annually buried without any medical certificate or inquiry whatever. In 1885 the number of these persons was 18,146; in 1886, 18,322; in 1889, 15,100. The number of exhumations ordered by the courts to detect poison has been less than one yearly. If cremation were universally adopted under the rules of the Woking Crematory, or, better still, of the Crematory Society of Zurich, such a state of things would be impossible.

The gist of the whole dispute between the advocates of cremation and their opponents seems to us this: Is cremation necessary in order to prevent the bodies of the dead from poisoning the living, and if so, when is it necessary? For obviously it is not needed in all cases and under all circumstances. In a country that supports but one person to the square mile it is not necessary. We should not think of enforcing it in the Highlands of Scotland, in Iceland and Scandinavia, or in Lybia. What is the use of burning a dead body where there is no risk of contagion? The dead on the battle-field and the victims of a pestilence ought, we think, to be buried. When

the population may be three hundred to the square mile we can easily imagine that cremation would be an admirable precaution. The purpose of cremation is, of course, to reduce a corpse to absolutely harmless ashes. The rapidity of the process, its completeness, too, recommends it. But though the combustion of a corpse is, beyond comparison, more rapid than its decay, yet the whole procedure of cremation is more complicated and requires more time than burial. Burial, indeed, is the most expeditious mode of sepulture. Under the law, a cremation can scarcely take place in less than two days, while a burial may be an affair of but a single hour. The point of chief importance is to remove the corpse as a source of contagion as soon as possible. In what way is this better accomplished than by means of burial? But it will be said that the speedy removal of the corpse, though a stern necessity in times of epidemic and something to be thankful for at all times, is not sufficient, as the risk of contagion is always present until the remains are wholly incorporated in earth.

Whether the interment of the whole corpse is so noxious a procedure admits of reasonable doubt. A writer in the *Annales d'Hygiene*, of recent date, infers from the results of excavations in Europe that the old method of burying in graves and trenches is, after all, the best and safest way of disposing of the dead. The evidence shows that infectious diseases are not engendered in those places. The earth purifies like fire. A cemetery properly situated is not a source of disease and contagion. A cemetery is objectionable when, as in very populous districts, it occupies a disproportionate amount of space or too little space. The latter condition is by far the worst. For the vast cemeteries, so common now, are merely a needless encroachment upon the living, but a cemetery too small is so frequently tenanted as to become a vile and contagious spot.

We revert to a consideration, often hinted at in the course of this paper, namely, that cremation should be adopted whenever it is a plain necessity. It is necessary whenever cemeteries are objectionable for reason just given; whenever, as in Germany, they become (as Coleridge expressed it) places not more dangerous to health than to morality; and finally, it may be said that cremation is intrinsically better than burial, for, though burial is seldom dangerous, cremation is never so; though burial is expeditious, cremation may be accomplished at least as rapidly; and the procedure of a cremation is even more decorous, is directed by even wiser legislation than the procedure of burial.—*Medical News.*

PHYSICAL EXERCISES AND FENCING.—We have received a copy of a lecture delivered at the Royal United Service Institution by Captain A. Hutton, late King's Dragoon Guards, in which that officer advocates the teaching of fencing to boys in the army classes at our large schools. The question of the advisability of teaching fencing to young people brought about a brisk discussion, in which the proposal, notwithstanding that it was supported by many of the speakers, was strongly opposed by others on

various grounds, and especially because it was alleged to cause an unbearable mental and nervous strain, and further, that in the case of growing youths it frequently produces lateral curvature of the spine and other deformities. All, or practically all, the large schools have nowadays what are termed army classes, which are devoted to preparing boys for army competitive examinations and a military career. Captain Hutton is desirous of encouraging boys to learn the art of fencing, and urges—correctly, no doubt—that a boy of fifteen, provided the instruction be sound and the teacher intelligent, will learn to fence in about one third of the time that is required to teach a grown-up man, although the latter may be only in the twenties. He would consequently have fencing partly replace the open-air games of football and cricket, which boys are now exclusively compelled to take part in. It is sometimes alleged that the physical training of youths intended for the army is neglected because all their energy is required for the mental strain necessary to prepare them for examination; and we are afraid that there is a good deal of truth in this allegation. With regard to fencing, as compared with other physical exercises, we are of opinion on hygienic grounds that fencing should not be allowed to interfere with such outdoor games as cricket and football, mainly because they are out-door and because they bring into exercise all parts of the body. As regards the assertion that fencing taxes the brain and nervous system more than any other form of exercise, to such an extent, indeed, that it becomes an almost unbearable mental and nervous strain, we should say that there is probably a certain amount of truth in this. Much will depend upon temperament. A boy of nervous temperament, who is eager and ambitious to excel in all he attempts, would probably feel the nervous strain of fencing, especially if his brain had been already exercised and possibly fatigued by his studies. Still, for the education and co-ordination of the eye, hand, and muscular sense, and the development of activity and prompt muscular action, there is probably no better exercise than that of fencing. From an anatomical and physiological standpoint, however, regular systematized exercises which produce a symmetrical development of the body are undoubtedly those best adapted for that period of life when it is actively growing and developing, but we do not believe that lateral curvature of the spine and other deformities would be induced in those who had not already a tendency to them, especially if the fencing exercises were limited to three hours a week.

London Lancet.

AMERICAN MEDICAL DIPLOMAS.—The British General Medical Council have recently resolved that the recognition of the certificates of the degrees of Doctor of Dental Medicine of Harvard University and of the degree of Doctor of Dental Surgery of the University of Michigan be suspended until further notice, and that the registrar be instructed to refuse registration of such certificates. Since 1879 these degrees have been recognized in Great Britain, and registration allowed under them. The reason for suspending

this privilege now is said to be that injustice is done to other American medical schools with equal educational standards, and to the British bodies, by placing them on a level with the diplomas of the two recognized American schools which require but three years' preparation, and over which the Council have no power of visitation and inspection.

THE next meeting of the Southern Surgical and Gynecological Association will be held in New Orleans on the 14th, 15th, and 16th days of November. Members of the medical profession are cordially invited to attend.

Special Notices.

J. L. SPITZMESSER, M. D., Windfall, Ind., says: I was called to see Mrs. W., mother of three children, aged twenty-three years; her weight, when first called to see her, was seventy-three pounds. She had been treated by eight physicians for muscular rheumatism of a shifting character, invading nearly all parts of her body and limbs, and a leucorrhœal discharge that had been a great source of trouble and annoyance, since birth of last child, then seventeen months old, with chronic metritis and left lateral displacement. Patient confined to her bed most of the time, of a nervous, irritable temperament, coughing and expectorating to an alarming extent, and without hope of ever getting well. Indeed, it was a hopeless case, one in which I could give but little hope and encouragement, as it had been treated by at least three or four physicians much my peers. I prescribed:

R Celerina, 7½ ounces;
Tincture rhus tox., 10 drops;
Fluid extract cimicifuga, ½ ounce.

M. Sig.: Teaspoonful every three hours.

R Aletris cordial, 8 ounces.

M. Sig.: Teaspoonful alternately with above.

Locally applied:

R S. H. Kennedy's Extract Pinus Canadensis (dark), 1 ounce;
Boracic acid, 30 grains;
Glycerine, 1 ounce.

M. Sig.: Lamb's wool thoroughly saturated, and womb kept in place by impaction of the above.

Patient was received May 16th, and discharged October 26th of the same year, cured, and is now doing her own housework; present weight is now one hundred and eight pounds. This case took three bottles of Aletris Cordial. I have other cases that I have treated in a good deal the same manner, with equally as good results, and my shelves are never complete without the above remedies in stock. I have got results from them that I have been unable to get from other sources.

The Phosphates of Iron, Soda, Lime, and Potash, dissolved in an excess of Phosphoric Acid, is a valuable combination to prescribe in Nervous Exhaustion, General Debility, etc. Robinson's Phosphoric Elixir is an elegant solution of these chemicals. (See page —.)

UTERINE COLIC AND OVARIAN NEURALGIA.—Two teaspoonfuls of Dioburnia given in a teacup of hot water will give almost as prompt relief as a hypodermic of morphia, and will produce no unpleasant after-effects.

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"*NEC TENUI PENNÂ.*"

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Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

ASEPTIC SURGERY FOR THE COUNTRY PRACTITIONER.

BY JAMES B. BULLITT, M. D.

The frequent use of the terms "antiseptic" and "aseptic" in surgery leads to the conclusion that there exists some cloudiness regarding the exact meaning of the two words. Formerly, since the days of Lister's first carbolic-acid spray up to a very short time ago, the general talk was of "antiseptic" surgery; that is, surgery in which chemical poisons were used of a sufficient strength to destroy living germs with which they came in contact. The use of such poisons was based chiefly on the belief at first entertained by Lister that the *air* was largely responsible for the infecting of wounds; hence his method of operating under a carbolized spray, and use of a most complicated and elaborate dressing. Carbolic acid was the agent first employed, and afterward bichloride of mercury played the chief rôle. The tanks of glass and other wares that adorned every well-regulated operating room attested the extent of the faith placed in these antiseptics. At this time the nail-brush, the pot of hot soap-suds and water, the kettle of boiling water, and the steam sterilizer were unimportant, and an operating room containing only them and no large bottles labeled "*poison!*" smelling of carbolic acid, or having the property of turning the hands black and rendering them rough as a day laborer's, would have been looked upon with holy horror by the ardent disciples of "antiseptics" in surgery, and the director of such an operating room would have been regarded as not in touch with the spirit of the times. Gradually the

truth began to dawn that it was not, after all, any thing but simple cleanliness that makes the difference between old-time mortality and that of the present day, and this simple cleanliness, not so very simple in attainment, however, constitutes the essence of the aseptic surgery of to-day as opposed to the antiseptic of a few years ago.

This distinction between antiseptic and aseptic may seem at first glance like hair splitting to some, but it is nothing of the kind. There is a difference in the terms, and a further difference in the technique of the adherents of the two kinds of surgery that is practically of the utmost importance. To state the difference briefly by example: The man who believes that antiseptics are the thing dissolves a tablet of corrosive sublimate in a pan of water, dips his hands therein, and proceeds to operate, and his surprise is great if such a thing as pus occurs or death from sepsis, and he is at a complete loss to account for such an event, because he remembers distinctly having made use of that magic tablet of corrosive sublimate. On the other hand, had he known that asepsis is the thing, had he expended five minutes brushing his nails with hot soap and water, had he been assured that his instruments were sterile, had he known that his dressings had been rendered likewise by dry heat or steam, he would have had no pus nor sepsis to marvel at, and would have spared his hands the roughening of the corrosive sublimate. It is not only the country practitioner who does not always know this; it is also quite a goodly number of "surgeons" in even some important medical centers, who are, happily for their own conceit, ignorant of these facts. Ocular evidence is the best of witnesses.

No longer than four years ago it was quite a novelty to see Robert Abbe flush out the abdominal cavity with simple boiled water. To-day it is the rule. He observed that strong antiseptic solutions acted on the tissues as well as upon the presumably present germs, and that the damage to the tissues was about as great as the feared damage of infecting germs. Gradually there came the dawning that if all articles, if hands and instruments, sutures, and dressings, and fluids which came in contact with wounds are sterile, aseptic, the result is the same, as regards sepsis, as when the most virulent antiseptics are employed, and the tissues are spared an injury from which they not infrequently have great difficulty in recovering. The only place which antiseptics properly have in surgery is in rendering some of the accessories (catgut, for instance) aseptic, sterile. Here disinfectants should be excepted, per-

haps, which are certainly useful in washing out stinking cavities and the like, and their action is in a certain sense antiseptic as well as disinfectant.

The statement can be made with impunity that, so far as aseptic surgery is concerned, carbolic acid and corrosive sublimate could be stricken from the armamentarium with advantage. This is not because they have no uses, though their uses are at best limited, but because their use gives a fancied security which constitutes a real danger. If the surgeon knew that their use alone, without the proper cleansing of hands, instruments, sterilizing of dressings, and the like, was exceedingly unreliable and dangerous, the matter would be different; but such is not the case. He has been led to believe that a corrosive sublimate tablet is all that is necessary, or at least that the only really necessary adjuncts are the stinks of carbolic acid and iodoform. If he has not been taught this, he has at least arrived at such a conclusion. Open ears at any meeting where the State is represented and heard will attest the truth of this statement. Our medical society brother must also wake up to a recognition of the fact that the frequent employment of the phrase "every antiseptic precaution" by no means guarantees that the described operation was aseptic.

All this, we beg, will be considered as preliminary. We will now consider how the country surgeon can satisfy his conscience by doing aseptic surgery. Not infrequently we hear a case described, an abdominal perforating wound perhaps, to which a city surgeon was called, or which was sent to a city surgeon because the country surgeon did not have the necessary appliances to do "*antiseptic*" surgery. When the proper idea of aseptic surgery supplants the erroneous one of antiseptic, we trust the voice of this excuse will cease to be heard in the land. It is quite legitimate and proper to lack courage or skill, but no one need lack the proper means and appliances to do aseptic surgery. Coats and cuffs can be removed, sleeves can be rolled up. If clean aprons are not handy, a clean towel can be pinned over the front. Hands and arms can be scrubbed for ten minutes in hot soap and water, particular attention being given to the nails, which have previously been cut short. The hands can now be rinsed in boiled water or alcohol, and the operator is ready. The patient can have had a bath (in set operations), or the field of operation can be thoroughly washed with soap and warm water, any hair being shaved. This can be followed by alcohol or ether. The table can be covered with a clean sheet, and the patient's

body or limbs with clean towels, and table and patient are ready for operation. These sheets and towels do not need to be soaked in any antiseptic solutions. Such wet cloths cool off the patient and are unnecessary.

Von Bergmann's assistant, Schimmelbusch, in his most excellent small work on the technique of Bergmann's clinic, relates the result of the bacteriological examination of sheets and towels which had been washed in the ordinary way by ordinary washer-women. Such sheets and towels are scrubbed and then boiled in a soda solution, afterward being ironed. This is the washer-woman's routine the world over. He found that such sheets and towels are rendered completely sterile. Of course care must be taken that no infection occurs after they leave the washer-woman's hands. In very important operations towels, etc., should be treated as the dressings are, to be hereafter described. This led to an investigation of the sterilizing properties of soda solutions. It was found that a boiling five-per-cent solution of ordinary washing soda is by all odds the best sterilizing medium yet discovered. All instruments that are to be used can be boiled for *five minutes* in this soda solution, and can then be regarded as safely sterile, provided they were already ordinarily clean. If they were afflicted with concretions and the like, they must first be scrubbed with soap and water. Boiling in this soda solution also prevents rusting, and keeps instruments beautifully clean and bright. It requires no fancy piece of machinery in which to do this boiling. An ordinary fish-kettle or any kind of pan or pot large enough to hold the instruments will answer perfectly. All this can be done, if necessary, in the house of the patient, or the instruments can be sterilized at home, wrapped in towels, and carried to the place they are to be used.

Dressings must be prepared at home. For them a steam sterilizer is necessary. This can be procured from any good instrument-maker. The ordinary cheese cloth or butter cloth, which can be bought from dealers at five cents a yard, answers perfectly for absorbent gauze. It is cut up into desired lengths, folded, put in the sterilizer, and steamed for one hour. It is then transferred to glass jars or metal boxes previously sterilized by steam or boiling, and set aside until needed. The fastenings of these jars must be air-tight, so as to let in no dust. Gauze so prepared serves all the purposes of borated gauze, salicylic gauze, sublimate gauze, etc., and can be so prepared at trifling cost. If iodoform gauze is desired, it is prepared on the spot by dusting iodoform

powder over this sterilized gauze. It is absolutely unnecessary to go through the troublesome process of preparing iodoform gauze with glycérine so as to render it permanently moist. Absorbent cotton, as procured from the supply man, is safe enough for ordinary use, but in very important places (abdomen, for instance) the proper thing is to put gauze, cotton, bandages (complete dressings, in other words,) in the sterilizer, pinned close up in a towel. This is steamed for an hour, allowed to dry out in the sterilizer, and not opened until required for use. Such dressings can be depended upon to be absolutely sterile.

The best, safest, and cheapest sponges are made from absorbent cotton and butter cloth. A bunch of cotton, larger or smaller as desired, is put on a square of butter cloth cut the size of a lady's handkerchief. The four corners are tied over the cotton and the "sponge" is complete. Such balls are steamed in the sterilizer and are then ready for use. They should be used *dry*; or simple pieces of gauze cut the size of large napkins answer also very well. The cotton balls and the gauze are much better than sponges because they are cheaper, more easily prepared, and can be thrown away after being once used. The cleaning of sponges is difficult, and when once infected they are always to be regarded with suspicion, and had best be thrown away.

In place of the large flat sponges, which are ordinarily considered essential in abdominal sections, Czerny, of Heidelberg, used square or rather slightly oblong pieces of heavy linen, cut about the size of a large sponge. A heavy silk thread is tied to one corner, and a pair of forceps snapped on to this when the cloth is introduced into the abdominal cavity, so there is no danger of losing it. These cloths, after being sterilized, are kept warm until ready for use. They serve to protect the intestines, which is the chief object of the broad flat sponges. Such sponges are very expensive, and the country surgeon can not very well afford to keep a supply on hand ready for use, waiting for a case to use them on. But he can prepare the linen cloths in an hour. Czerny's outlay of dressings, etc., was very elaborate and lavish, and it was not through economy he employed these cloths, but because he found they answered the purpose better than the sponges.

This leaves only sutures, ligatures, and drainage-tubes to be considered. The small consumer will do best to buy catgut already prepared and ready for use in glass bottles. If from a good house it is fairly reliable, and saves somewhat troublesome manipulations. Silk is to be wound on reels, glass or wood, and boiled for fifteen minutes in the

aforementioned soda solution, and is then preserved in tightly stoppered bottles or boxes, *dry*. If desired, it can be immersed in a five-per-cent solution of carbolic acid. In important operations it is good practice to drop the silk in with the instruments and boil again immediately before use. Rubber drainage-tubes are simply prepared by boiling for *five* minutes in the soda solution, and then are permanently preserved in long glass bottles in a five-per-cent carbolic solution. Now this is *all* that is required to do the most modern aseptic surgery, and is so simple and uncomplicated that it is in reach of every country surgeon who pretends to do any surgery at all. There is no necessity for deluges of water, antiseptic or otherwise. The patient's bodily warmth is thereby reduced, and the floor is converted into a pond, when it had just as well remain dry in most cases. It must be remembered there is as much danger of washing germs *into* an uninfected wound as hope of washing them out if they were there. Use just enough boiled water to remove blood stains and secure cleanliness. If fluid is required for flushing out a cavity, nothing can answer the purpose better than simple boiled water, unless indeed it be a physiological saline solution, which we are inclined to believe is, after all, the proper solution to be used in flushing out such cavities as the abdominal and pleural.

In Von Bergmann's clinic, probably the most modern and perfect in technique in Europe, the dry method of operating proposed by Launderer is used exclusively. No sponges are used. A sterilizer containing gauze cut in squares like handkerchiefs stands at hand. As the incisions are made, bleeding points are immediately caught up, the blood being taken up by the pieces of gauze, which are thrown away as fast as saturated. In this way the cut surfaces are kept absolutely dry, and when brought together at the close of the operation are in ideal condition for primary union. This dry method, when once seen, commends itself forcibly and for all time to the reason.

Finally, it is to be borne in mind that it is almost always the hands and implements that are the sources of infection, almost never the air. The detail of technique is of course only to be learned by extended practice or observation in a well-organized clinic.

TYPHOID FEVER; ITS IMPORTANCE.*

BY J. FULTON PURDOM, M. D.

That typhoid fever is a question eminently important and well worthy the serious consideration of any practitioner of medicine is a fact that will not be disputed, and yet, judging from current medical literature, the fact is clearly established that there are but few men giving special attention to the investigation of the subject.

In the opinion of the writer the disease from its importance demands more attention than it is now receiving from the profession, either in discussions before medical societies or in papers published in medical journals.

It is a lamentable fact that the practitioner of medicine manifests a decided timidity in pressing the claims of his opinions before a medical society on a subject so common as typhoid fever, notwithstanding the fact that he will see twenty or more cases where he will see one of appendicitis, ectopic pregnancy, or ovarian tumor, and notwithstanding the fact, also, that he will perhaps record three or more deaths in the same number of cases, apparently forgetting that he sustains the same relation to those cases and to the discussion of the subject before the medical societies that the surgeon does to appendicitis, ectopic pregnancy, ovarian tumors, etc.

How differently the surgeon acts with reference to his side of medical science. He comes boldly to the front and justly demands and receives our time and attention in the presentation of his opinions relating to surgical pathology, technique, and the various operative procedures intended to alleviate human suffering and prolong life. So long as surgical pathology was left to the judgment of the book-makers the peritoneum was the bugbear to the operator; idiopathic peritonitis was not questioned; men and women died from conditions the real nature of which the medical attendant had but a vague idea. But when men in active practice began to think for themselves and to express their opinions as individual investigators, searching for facts that were beclouded with doubt and hidden by empiricism, surgical pathology was rewritten, and has become a matter of scientific knowledge which forms the basis for improved technique and operative work so brilliant in its results that it commands the admiration of the world.

* Read at the May meeting of the Kentucky State Medical Society, 1893.

The medical practitioner should feel an equal interest in all that pertains to his department of medical science, realizing the potent fact that the underlying principle of all real success in the administration of drugs is a proper understanding of the pathology of the disease he is trying to cure, a knowledge of which necessarily comprehends the etiological factors by which the pathology is produced.

The subject of typhoid fever is an important one for discussion; first, because the disease has not an established pathology; second, because its destructive influence is not limited to time or place; but the disease may occur anywhere, or at any season, dependent always upon the ingestion of the specific cause. It is important because of its high rate of mortality, and because of the fact that the majority of those who die of typhoid fever are young adults, usually vigorous, healthy people until attacked by the disease; important because of the long duration of the illness of the patient suffering with an acute disease, and the extreme anxiety of the friends of the patient, which is increased tenfold by the fact that the profession make no claim to their ability to cure the disease, frankly confessing that we can only help the patient to outlive a condition the nature of which we do not understand, not being able even to offer a reason for the self-limitation of a disease so common to almost every country, and that has destroyed so many of the physically most promising young people.

The subject is one of importance for discussion, because exchange of opinion is the greatest means possible to stimulate original investigation, without which we can never have an established pathology, and in the absence of an established pathology based upon scientific investigation we can never have a uniform system of treatment. So long as the confusion continues that now exists with reference to treatment we can not hope to lower in the aggregate the present high rate of mortality. As an evidence that confusion in treatment does exist, and that there is not an acknowledged scientific basis for a uniform system of treatment, we find one man says the internal administration of antipyretics is indicated, another says not; another says intestinal antiseptics should be given, and another says they are without value; one man says feed your patient, another says feeding aggravates the disease; one man says whisky is the most potent remedy we have, so much so that he gives in some cases a quart per day; another says his patients do best without alcoholic stimulants; one man gives antiseptics that are absorbed by the stomach with a view to influence the specific cause in the blood; another says antiseptics of that character never reach the specific cause.

I recently heard a doctor state before a medical society that there was but one treatment for typhoid fever, and that was the cold bath. He stated that the cold bath treatment should be made compulsory by law, and yet the same gentleman, when asked to discuss the pathology of the disease, declined to do so.

In the opinion of the writer the subject becomes especially important because of the fact that the pathology as laid down in the text-books is entirely unsatisfactory and absolutely misleading, and is responsible for the confusion that exists relative to the treatment of the disease. The only means of escape from such a state of confusion is that we no longer leave the pathology of the disease to the judgment of the book-makers (who are to a great degree only compilers of stale medical literature), but by the expression of independent thought from the active practitioner, stimulating original investigation, the truth may be arrived at, and a correct pathology established which will form a scientific basis for a uniform system of successful treatment.

That typhoid fever has a pathology we will all agree, but in what that pathology consists we may differ widely. As intelligent practitioners of medicine we are forced to admit that all therapeutics are empirical unless they find a scientific basis for their administration in the pathology of the disease under treatment.

A knowledge of the etiology of disease when taken alone does not form a scientific basis for treatment; for unless we understand the mode of entrance and can locate the point of attack made by the specific cause, and determine the limit of tissue invaded, with due regard for the product that may be formed as a direct and necessary result of the increase of the specific cause, having an intelligent appreciation of the separate and combined action of the specific micro-organism and its toxine, and the pathological avenues which may be opened up through which other micro-organisms may become active, we are not *fully* prepared to treat the disease from a scientific standpoint.

Koch's discovery of the tubercle bacillus was practically the key to the etiology of typhoid fever and many other diseases. His discovery of tuberculin has become equally the key to pathology; for when it was demonstrated that a diffusible product was formed as a necessary result of the growth of the tubercle bacillus, men readily extended the application of the same principle to their investigations of the growth of other micro-organisms. It must now be acknowledged as a law in biology, that all disease-producing micro-organisms furnish a diffusible

product as a necessary result of their growth, constituting a second factor in the process of disease which can not be disregarded in the study of pathology.

In the absence of the specific cause an individual can not have typhoid fever, though he be surrounded by the most unwholesome conditions. With the ingestion of the specific cause he may have the disease, though he be in the midst of the most favorable hygienic surroundings.

We will assume that there are but few men to-day who dispute that typhoid fever is produced only by a specific micro-organism, which we will here call the typhoid bacillus. While we will admit the possibility of the bacilli being taken on to the fauces from the atmosphere, in the act of inspiration, yet we most emphatically deny their ability to produce the disease except they be swallowed and escape the action of the stomach and find lodgment in the glands of the small intestine from the lumen of the bowel, and not from the blood. With one or more of those glands thus infected the individual has typhoid fever, though not manifest even to the patient until systemic symptoms arise. The bacilli infiltrate the glands infected, and their action in the development of the disease is entirely local, which results in a non-suppurative necrosis of the gland tissue. With the beginning of the growth of the bacilli in "Peyer's patches" we have furnished a diffusible toxine which is readily absorbed and transmitted to every tissue of the body. To the action of this toxine is due all the systemic symptoms prior to necrosis of the glands infected. The nervous system being most sensitive to the action of poisons circulating in the blood, the typho-toxine through its action on the nervous system produces a pathological state of every function of the body which is first manifested by faulty elimination, the retention of waste products thus decreasing the ability of the system to resist the action of the typho-toxine, which is not only acting upon the nervous system, but is affecting every tissue of the body both directly and indirectly, thereby rendering the system less able to resist the action of other micro-organisms that may enter through the lymph or blood channels later in the history of the disease. When necrosis has taken place in "Peyer's patches" the system is no longer able at those points to resist the action of the pus-producing micro-organisms. Ulceration now takes place as a result of the action of the pus-producing cocci, and may extend through the walls of one or more blood-vessels, being made manifest by greater or less hemorrhage, or, the ulceration may be

extended through the walls of the bowel with a fatal peritonitis. The action of the pus-producing micrococci is in no sense a part of the specific element of the disease, but is a complication in the fullest sense of the term; for they can act only through and as a result of the pathological conditions produced by the specific bacilli and their toxine. An increase in local lesions is by no means the only complication that may arise as a result of the action of those non-specific micro-organisms. They, like the specific bacilli, furnish products that are absorbed, in addition to which the micrococci may be carried through the lymph and blood currents to very remote portions of the body, and produce pus formation in consequence of the lowered vitality of the system resulting from the previous action of the typho-toxine. Some of the specific bacilli may also be carried through the lymph channels from the infected glands, being taken up as *detritus* along with the products of necrosis and suppuration.

In support of the statement that the action of the specific bacilli in the development of the disease is confined to the infected glands of the intestine, and that their presence elsewhere in the body is purely incidental, it is only necessary to refer to the fact that the intestinal lesions are the only characteristic pathological changes that are found, which could not be the case if a dissemination of the bacilli through the body was necessary to the development of the disease. The proposition is too clear to admit of argument. That the self-limitation of typhoid fever is not dependent upon the development of an anti-typho-toxine is clearly proven by the fact that we have relapses, which would not occur if the anti-toxine had the power to arrest the primary attack, for it would require less to prevent than to cure.

The most reasonable explanation of that meaningless phrase, "the disease must run its course because it is self-limited," is to be found in the fact that the action of the specific bacilli is local and confined to the infected "Peyer's patches," consequently the disease can continue as typhoid fever *only* so long as is required for the bacilli to consume the tissue in the glands infected, relapses being dependent upon the infection by the specific bacilli of glands that were not involved in the primary attack. All cases that have a return of elevated temperature after convalescence has begun are not necessarily relapses of the disease in so far as relates to its specific character, but may be and often are due to the action of other micro-organisms as a sequel of nature's loss of resistance. The bacteria of decomposition being always present in the

intestinal canal, the gases resulting from their action on the contents of the bowel may become a factor of material importance in the history of the disease. It is to the action of this class of bacteria that we must ascribe the tympanites that occurs, though they become active only after the pathological conditions have been more or less established by the specific factors of the disease.

The word "treatment" is indeed a comprehensive term, yet we affirm that if scientific medicine indicates any thing, it indicates intestinal antiseptics in the treatment of typhoid fever; but that does not signify that we ignore the fact that each case possesses an individuality, for upon a proper management of the case in detail will depend largely the success of the remedies intended to act upon the specific cause.

LOUISVILLE.

BACTERIOLOGY: A REPORT.*

BY LOUIS FRANK, M. D.

Your committee has found that the literature during the past year relating to his subject is so voluminous that to report only the practical and important facts brought out would make a paper of many pages, and would therefore ask that you pardon what may seem a short or at least a restricted report.

Of greatest importance has been the work done by our colleagues across the seas in regard to that dread scourge, Asiatic cholera, which for a time was knocking at our own doors. The early and certain diagnosis being of the greatest value, and this diagnosis being made with certainty only by our culture methods, I do not deem it amiss to describe the bacillus and its various characteristics.

When, in 1883, Europe was threatened with this terrible disease, the German Government organized an expedition to investigate its cause, and placed at the head of this expedition "the father of modern bacteriology"—he who in 1882 had demonstrated the cause of tuberculosis—Robert Koch. In a short time he was able to report the finding in all cases of the disease, both in the stools of the living and in the intestines of those dead, an organism called, on account of its shape, comma bacillus. This bacillus he held to be the true cause, the *sine qua non*, and this we know it has proven to be.

*Read at the May Meeting of the Kentucky State Medical Society, 1893.

This bacterium possesses certain characteristics which enable us to positively differentiate it from all others, and which when found enable us to say with absolute certainty that we have a case of true Asiatic cholera. The bacillus is a short, thick rod about half as long as the tubercle bacillus, but thicker and slightly curved, and in some cultures, especially when old, we find them as long spirals; these latter forms, however, being not true forms, but being caused by imperfect segmentation as a result of degeneration. In fresh cultures they occur singly or in chains of two or three, often in "S" forms; they possess motion, produced by a single flagellum attached to one end only, as has been demonstrated by Loeffler.

It is generally believed that they do not produce spores, though Heuppe has claimed the contrary, and there are several things leading us to believe that, even if they do not, they at least exist at times in a state more resistant than ordinarily. This resistance, however, is only in certain directions, as we know the slightest amount of mineral acid either destroys or prevents growth—an important point in preventing infection. A temperature of 50° C. as well as drying soon destroys them, and cold is popularly supposed to kill them.

Below 15° C. no growth takes place, nor above 42° C. In the incubator at 37° C. growth is most rapid, though they also flourish at 20° to 22° C. Oxygen is required for their growth, still they multiply and destroy life when introduced in the intestinal tract where there is no oxygen—an interesting fact.

Neither on agar-agar nor on potato do they possess any thing peculiar in their growth, but on nutrient gelatine their appearance is characteristic. If inoculated by stab in a gelatine tube, we find that the growth occurs along our entire line of inoculation, but more rapidly at the surface in the presence of oxygen, where liquefaction of our media rapidly occurs, with a peculiar funnel formation, having at its upper portion a large air bubble with the principal mass of bacteria just below the funnel; our inoculation line extends as a clear tube into the gelatine, and organisms are also collected at the lower portion of this culture. This appearance is very striking and possessed by few other organisms. Later in its growth the entire tube of gelatine becomes turbid and liquefied, the bacilli lying at the bottom of the tube, while at the surface we observe a thick scum composed of *bizarre* forms which are numerous and varied, resulting from degeneration of the bacilli. The rapidity of their liquefaction depends upon the temperature, and

their rapidity of growth upon the reaction of the gelatine. We may also find, if our gelatine is not sufficiently alkaline, that no growth whatever of these organisms will occur; on gelatine containing only 0.05 per cent soda cultures are negative. This may lead us into error in examining stools of patients, and should always be remembered. On gelatine containing 0.1 per cent the growth is slight, but it increases in rapidity of growth up to its best development, which occurs in 1 per cent soda gelatine. After eight weeks gelatine cultures are completely liquefied, and they at this time lose their transmissibility, though on agar they retain it for as long as nine months even under supposed unfavorable surroundings.

On milk they thrive well, dying off as the milk becomes acid. In water they grow excellently, no matter what the source of the water; this is especially true in filtered water or sterilized water. In unfiltered water they are soon destroyed by the water bacteria. The reaction with pure HCl or H₂SO₄ is not possessed by the cholera bacillus alone, but is not possessed by any other organism resembling it, so that it may serve as a rapid means of diagnosing from other vibrios.

Inoculated into non-sterilized milk fifteen minutes after milking, and maintained at a temperature of 37° C., we find that they increase for from three to six hours; at a temperature of 22° to 25° C., for from ten to fifteen hours, the increase here being very great; at from 8° to 10° C. there was no increase, and colonies were no longer found after two to three days. In all they were alive in from one to one and a half days after inoculating milk. Its life here, however, depends, as I said, on the acidity of the milk, they dying as soon as the milk is sufficiently acid. These are important points in considering the spread of the disease and the manner of contagion. In milk previously sterilized and kept at 37° C. they lived for two weeks, and at 20° C. for longer than three weeks. Boiling has been shown to be the simplest and easiest way to rid milk of the bacilli, provided during epidemics it is used immediately and not allowed to stand open and liable to reinfection, when they live better than in the unsterilized milk as shown. Milk then may be a prolific source of infection, and its care and preparation become of the greatest importance, especially in cities or where milk is obtained from delivering dairymen.

Weyl has shown that even in beer which has not been sterilized they live for twenty-four hours, and may be found, as he demonstrated, by the plate method; after twenty-four hours, though, they die—some satisfaction for the beer-drinkers.

Cultivation on gelatine is the only absolute means of diagnosing the presence of the bacilli, and thus of true Asiatic cholera. This is of especial importance, not only in the first cases of an epidemic, but in all cases during an epidemic, as has been shown last year; also in considering how long persons recovering shall be kept in quarantine. Early in epidemics, or rather during epidemics, many cases of cholera morbus are undoubtedly mistaken for true cholera, and at this time we are especially apt to have severe cases of cholera morbus. These mistakes cause inestimable harm and should not be made. Again, we may have mild cases of cholera where symptoms are so slight that they never present the picture of even a cholera morbus. In these light attacks cramps may not exist as a symptom, and we may have only diarrhea and vomiting, or even the vomiting may be wanting and the diarrhea be the only symptom present, this lasting only a few days, the patient feeling not at all badly; but even in these cases the comma bacillus being present shows them to be cases of Asiatic cholera. Again, in other cases presenting all the characteristics and symptoms of the disease the examination of the stools shows their absence, as the following case illustrates:

A woman of sixty-two, returning on August 24th from a visit to relatives in Hamburg, presents herself at the hospital with a slight diarrhea. At first she felt tolerably well, but on the 29th there set in an uncontrollable diarrhea, violent vomiting, and rapid sinking. In a short time the skin was able to be lifted in folds, which would remain; patient voiceless, severe cramp in the calf of the leg; she became comatose, death resulting on the 31st. The intestinal contents had not the rice-water appearance, but were of fluid consistence, stained with bile, and scattered through with yellow glass-like particles of mucus. The comma bacillus was not found; instead the *B. coli* commune with a streptococcus. In this case the fact that she came from Hamburg made the diagnosis almost sure, and disinfection was carried out in the usual way until the examination after death, when the body was allowed to be taken away, no suspicious cases even arising as a result.

As an example of the other variety of cases, we have the case of Mr. B., musical director, from Hamburg, who arrived in Berlin from the previous place at 6 A. M., September 15th. He went at once to the municipal disinfecting station for observation, as he had had, after taking some "cholera drops," some gaseous eructations. From the station he walked to the hospital. Immediately after arrival, between

10 and 11 A. M., he had a diarrheal stool; then, between 16th and 17th, and between 17th and 18th also, three stools of same character; no vomiting; no cramps. Felt absolutely well during his stay at the hospital. In one of the stools of 17th numerous comma bacilli were found, and a plate of the same, after twenty-four hours' growth, showed also numerous colonies of the organism.

Where quarantines exist persons should be kept there until the organisms are no longer found in the stools, which may be a variable length of time; for, so long as the bacilli are present, just so long are these persons capable of spreading the disease. During this time the stools should be disinfected, and as the best disinfectant milk of lime, 1 to 4, has been most efficacious, rendering them sterile within one hour. The method of carrying this out has been to bring in the vessel a quantity of milk of lime equal to the stool; this is shaken well and allowed to stand one hour, when the disinfection is absolutely complete. Utensils capable of standing it should be disinfected by dry heat, other substances by steam, for two hours, taking care not to try to disinfect too much at once. As quarantine measures, neither the forty days' detention nor the shotgun cordon is of any use. The epidemic of last year and also of previous years has shown that on land these means are absolutely valueless and incapable of preventing the spread, while in those instances where infection is through seaport we may hope for better results. But even here, with the strictest precautions, cases will occur, as was illustrated recently in New York. In considering quarantine measures these facts must be borne in mind, as they show the inefficiency of such methods. Better results in preventing spread are gotten by inspection and observation of travelers for a few days, both at points of beginning and ending of journey, with the issuance of certificates, which latter, however, must be reliable. Provision should be made for disinfection of stools of those traveling, as when cases do occur this is a frequent source of spread, on account of the construction of the closets in railway carriages. However, when cases at all open to suspicion do occur, they should be at once isolated, a bacteriological examination made of the stools, and, if proven by this examination to be the disease, should be detained until the bacilli disappear from the feces. The effects should be sterilized with dry or moist heat. In no case should those not having the disease, even when from infected places, be compelled to remain with those having the cholera; they should rather be allowed, after disinfection of luggage, to proceed on

their way, being kept under surveillance by the health officer at the point of destination. The spread of cholera would in this way be less than if we rely on making fixed lines through which we endeavor to keep it from passing. The laity should be educated not to fear, as there is absolutely no danger from contagion, and the spread from any given case can be prevented. There would then be no necessity for smuggling in persons from cholera districts; the people would gain confidence in our prevention measure, commerce would not be so demoralized, more and possibly many would not die of fright. The people should be instructed in hygienic measures, not by the police, but by competent physicians under control of our health bureau.

Inspection of the premises should also not be left to the police, but should be done by a qualified hygienist. A factor which we have not studied thoroughly until lately, a source of infection that all quarantine measures, be what they may, can not control, is the spreading of the disease by flies. Flies allowed to feed on infected material show, by the plate method two hours afterward, that their excrement contains, beside an inestimable number of saprophytic, also cholera cultures.

After from six to twenty-four hours proportionately less numbers of saprophytes are found and relatively more cholera organisms. Numerous control experiments made at the same time showed the absence of the organisms in the excrement from these flies. In the intestinal contents of flies fed on pure cholera cultures, as also in their excrement, the organisms were found after one, two, and three days. The intestinal contents of flies fed, not on a pure culture, but on the intestinal contents of one dying of cholera, showed the presence of Koch's bacillus, and also others found ordinarily in the place from which the infecting material came.

The virulence of the organisms found were not in the least diminished, as shown by injection into guinea-pigs and into pigeons. It is quite probable that the bacillus does not possess the power to multiply itself within the flies.

These facts show us "that flies are to be regarded not only as a spreader of infection, but also as a source from which our foods are constantly contaminated with new and fresh generations of the cholera bacteria."

In the prevention of cholera we may hope for something in the way of artificial immunity which Haffkine and others were able to produce in the guinea-pigs.

Haffkine, having rendered the animals unsusceptible to intra-peritoneal injections, tried the same experiments on man. He injected himself with a large dose of the same virus (premier vaccin anti-cholérique) with which the pigs had been rendered immune. After the injection there was some ill feeling lasting twenty-four hours. The temperature rose from 36.6° to 37.5° C. There was no digestive disturbance. Some slight local reaction was present, consisting of swelling of the skin and also of the lymphatics on the same side. The pain disappeared after five days, the swelling remaining for four more days. Six days after this inoculation he allowed himself to be injected with a very virulent cholera virus (second vaccin anti-cholérique). The temperature rose to 38.6° C.; no swelling of skin or glands; felt normal after twenty-four hours. Pain at seat of injection remained three days; no digestive disturbance.

A colleague weighing seventeen kilograms more than Haffkine was then injected with the same dose of the weakened virus. Local and general reaction were a great deal less marked, and rapidly disappeared. On the sixth day an injection of the virus exalte was given without any reaction. Other experiments showed about the same result. From these experiments Haffkine expresses the hope that man may be rendered perfectly immune six days after receiving an injection. The vaccine has no dangerous effect on the health.

Other experimenters have been able to produce immunity by injections of virus obtained from the cultures. Also, by injection of the blood serum from a woman recovered from cholera, guinea-pigs have been rendered immune.

The experiments of Pettenkofer and Emmerich have not proven any thing new, unless it be to more fully establish the bacillus as the cause.

Koch, in his earliest publications, stated that not all were susceptible, only possibly two in every five. That both Pettenkofer and Emmerich had cholera I believe all will agree who read the publication. Pettenkofer's case was very mild; Emmerich's was more severe, so much so that he felt called upon to take tannic acid and opium as astringents and cocoa and red wine for stimulation.

Just such cases as they had were seen in Hamburg and other places, one of which I have given.

All diseases vary as to severity, and while we must admire the scientific spirit exhibited, nothing that was at first asserted by Koch

has been disproven, nor has, as some anti-bacteriologists claim, any harm been done to our branch, which, though only a few years old, has made more rapid advances and been of more practical service, especially to the surgeon, than any of the allied sciences of medicine.

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LOUISVILLE.

NITRATE OF ACONITINE IN FACIAL ERYSIPELAS.—Tison (*Sem. Med.*, August 25, 1893,) was first induced to use this remedy in 1888, and has employed it subsequently in every case of facial erysipelas which has come under his treatment. The results have been highly satisfactory, pain and other symptoms having been rapidly subdued, save in two instances, and in neither of these could the complications which arose be due to the treatment. Although the nitrate of aconitine is highly poisonous, and it may be objected to by some on this account, if used as now suggested the danger of untoward symptoms is very slight. The alkaloid is dissolved in a mixture of glycerine, alcohol, and distilled water, the mixture having the same specific gravity as water, and containing one milligram in fifty minims. Only two to four milligrams are required in any one case. The method of procedure is as follows: According to the condition of the stomach, either an emetic or a purgative is administered, immediately after which nitrate of aconitine is given in a mixture containing one milligram for the twenty hours' dosage. The affected part is painted with a saturated ethereal solution of camphor, which acts as an excellent sedative. When all signs of inflammation have subsided the part is washed with a solution of lysol.—*British Medical Journal.*

Reports of Societies.

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.*

Stated Meeting, September 29, 1893, Dr. T. S. Bullock, Vice-President, in the chair.

Dr. E. R. Palmer (Obstinate Serpiginous Sores): This patient you will remember I exhibited before this Society during the month of July. He has a characteristic serpiginous sore in the right groin and also a sore on the penis just back of the glans. The first appearance of the sore on the penis was in August, 1892, a few days after intercourse. He was treated in December, 1892, at the University Clinic, with no improvement, and came under my care in February last. The ulcer in the groin has been curetted; we have applied carbolic acid, boric acid, iodoform, bromol, dermatol, peraseptol, sub. iod. bismuth, acetanilid, etc., and his condition to-day is about the same as when he was before the Society in July. He gives the history of having had syphilis six or eight years ago, which, however, I think has no connection whatever with the present trouble. The case is one of extreme interest to me, as it has resisted all forms of treatment from the simplest to the most heroic. Electro-cautery has been applied to the sore in the groin several times, but no improvement resulted. Bovinine dressings were applied every day for a month without effect. Glycerole of papoid has been thoroughly tried, and has done some good. Both sores are in practically the same condition that they were a year ago.

DISCUSSION.

Dr. T. H. Stucky: As the destructive process seems to have been checked as compared with what it was, I should incline to the belief that the best mode of treatment at this time would be to excise the entire mass, bring the edges together, and convert it into an open wound. I see nothing else that can be done, unless it be to shave off a portion of the surface and allow it to heal by second intention. If the glans is involved, I would suggest complete removal of it by converting it into a simple wound.

Dr. H. A. Cottell: In regard to the pathology the question is, what is the nature of this sore? Is it simply a chronic ulcer, or is it of the

*Stenographically reported by C. C. Mapes.

nature or character of chancroidal sores, as we commonly see them, or is there not in this case a tendency to malignancy—possibly malignancy already there? I would like to examine specimens under the microscope to see if the growth has not some characteristics of epithelioma. We know that all chancroidal lesions get well promptly. The sore in the groin may be of the nature of cheloid, but I should not think this was the case with the preputial sore.

Dr. W. L. Rodman: I take the same view of this that Dr. Stucky does; it either ought to be curetted very deeply and the unhealthy tissue removed, or, what would be still better, a complete dissection of it, making an elliptical incision, removing the piece entirely, and bringing the edges together as in a fresh wound. I do not think it is likely that there is any epitheliomatous change in either of the sores. The man's general appearance, age, and condition would seem to me to be against this idea. Epithelioma of the penis is extremely rare, and when it does occur is generally seen in subjects past fifty. I have seen but one case under forty, that was in a man thirty-seven. This young man is, I should say, about twenty-two.

Dr. E. R. Palmer: Several times since this patient has been under my care the sore in the groin has looked as though it were going to heal, and we would feel quite encouraged, but probably by the next day the little bridges of skin which had partially formed over its surface would be broken and its condition would be the same as before. In regard to incision and removal of the sore in the groin, of course this could be done, but as electro-cautery has been employed several times without benefit it is questionable whether it would effect a cure. I will have a section removed and sent to the laboratory at the University, with the request that a careful microscopical examination be made to determine whether it has any of the characteristics of epithelioma or not. Of course the sore on the penis could not be excised, as it would involve cutting into the corpus spongiosum. I believe it is a case that will puzzle a great many physicians before healing takes place, as I have resorted to the most heroic measures without appreciable effect. I will say that the sore in the groin has never extended its limits at all, its shape and size being now about the same as when the case first came under my observation.

Dr. J. W. Irwin: What course of mercury did you use?

Dr. Palmer: This patient has been given prot. iodide of mercury in one-third-grain doses, has been given mercury by inunction, and has

received iodide of potassium in sixty-grain doses three times per day. If any other suggestions can be offered as to treatment I should be very glad to receive them. I think the most important thing to do now is to have a careful examination made with the microscope to determine, if possible, the exact nature of the trouble.

Dr. Irwin: The reason I asked the question is because when I was a medical student, and the older Dr. J. Pancoast was alive, he had a great many of these chronic disorders to treat, and he brought them before the class. I have seen as many as twenty-six cases of bubo and venereal diseases standing around the room before the class at one time. He came across a case very much like the one you have described, and every form of mercury had been used in the treatment of this case before it came under his observation. The patient had been treated in Blockly Hospital for a long time without any effect. Some microscopist had pronounced the trouble to be cancerous; Dr. Pancoast believed it was syphilitic. Green iodide of mercury in one-fourth-grain doses was given this patient four times per day; the sores were dressed locally with a solution of mercury which is common to all, nitrate of mercury one part and water twelve parts. In less than six weeks the effect of the mercury was so apparent that there was no longer any doubt as to recovery.

Dr. Palmer: So far as the specific action of mercury upon syphilis is concerned I do not think there is any question, but the inunction treatment, properly performed, is the most effective. In regard to green iodide or any other preparation of mercury, I believe it to be a fact that they all turn to chloride before they are absorbed.

The patient shown here to-night has certainly been thoroughly mercurialized; he has had powerful iodide treatment, in fact has received every conceivable manner of treatment except the injection of mercury.

Dr. Wm. Bailey: I would like to ask if this patient is very tolerant of anti-syphilitic treatment, and if so, is this not an evidence that the trouble is syphilitic in character?

Dr. Palmer: It has been absolutely established that this is not the case. It has been established beyond peradventure that some patients may take enormous doses of iodide of potassium without syphilis and without producing iodism; on the other hand there are patients who, with syphilis, can not take three grains of iodide without producing a most distressing case of iodism.

Dr. J. A. Larrabee: I would like to make a suggestion, that this

patient be allowed two weeks more before any operation is performed, and have a daily application of "milk of Alvelos."

Dr. A. M. Cartledge: The question arises, what are these so-called serpiginous chancroidal sores? Every thing points to the fact that they are tuberculous lesions most certainly. First of all I think the chancroidal virus is due to a specific organism. This organism does not under ordinary conditions act in the manner as described here. I think a microscopical section is really the only possible way of ascertaining the exact nature of the trouble in this case. The incision suggested by Dr. Rodman will almost certainly cure this patient; there is scarcely a doubt about it. The question Dr. Palmer very rightly asks as to whether there is not some less radical measure that would secure the same end, I firmly believe that if practicable to do a thorough curettement it is possible to cure this trouble—a thorough, complete, and deep curettement down to the very base of healthy connective tissue, as well as every part of the permanent tissue base—I believe that you could curette this sore on the penis and the ulcer in the groin so thoroughly that even a simple dressing without an antiseptic would result in complete cicatrization. This could not be done to advantage with cautery, as the cautery can not be controlled to the same extent as the curette. If this trouble be of a tuberculous nature, which I believe it is, I do not see how you would know when you had destroyed with cautery all of the tuberculous material. In cases of this character I believe that the curette should always be tried before resorting to excision.

Dr. Palmer: I think that the curette is a little uncertain. We have here a sore that, while it is called serpiginous, yet it has not all the characteristics of such a condition. By the term serpiginous we mean a sore that keeps winding and turning, one that heals behind and advances, then back to destroy what has healed. This sore, as you will observe, is about the length of a finger, and has remained just about as you see it now for over a year. It has never extended in one direction or another beyond a distinct line in the groin.

Dr. Cartledge: Of course we may have all manner of modifications in a sore of this kind. It clearly belongs to that chronic form of ulcer to which we apply the name of serpiginous.

Dr. Palmer: I have been absolutely unable to discover any thing specific about a chancroid; I believe that the simplest herpes may become a chancroid. A man may have a chancroid who has never been infected at all, one who has had no possible exposure to contagion.

Dr. Cartledge: Do you think it is simply pus infection?

Dr. Palmer: It is possibly due to pus infection; there is no specific micro-organism or specific action about a chancroid.

Dr. Rodman: I believe that Dr. Cartledge has perhaps suggested the true pathology of this condition. I think it is very likely lupus, in which case it is not by any means incurable. The patient's age would suggest lupus, as nine-nine cases out of a hundred occur before the age of thirty.

Dr. Rodman (Double Hydrocele; Operation): You will remember that at the last meeting of this Society I presented a patient suffering from double hydrocele; the man had a very large tumor upon the right side, of typical pear shape, and a smaller tumor upon the left side of the scrotum, both tumors having appeared within the last four weeks. I made the diagnosis of double hydrocele, which was a rather unusual condition in a man forty years of age; another peculiar feature was that they had grown so very rapidly. At the time the patient was presented there were two gentlemen (I am sorry that neither one is present to-night) who, after examining the left side, thought there was some thickening or degeneration of the cord, possibly of a tubercular nature. On this account I promised then to make a further report of the case at the meeting to-night, and as the patient was still in town I thought the case of sufficient interest to ask him to come again before the Society. He leaves for his home to-morrow. There was absolutely no thickening of the cord; it was as natural as any cord I have ever seen after removal of the fluid. I present here the fluid which was withdrawn, and you will observe it is the typical amber color. I think the prognosis is very promising. There is some little edema about the scrotum from the injection of carbolic acid, but the patient has never had any fever or pain since the operation, which was done last Saturday. Both hydroceles were operated upon at the same sitting. I injected two drams of thirty-three-per-cent carbolic solution into each sac; there has been no unfavorable symptom. I prefer carbolic acid to iodine, as the reaction is very great in some cases after the use of the latter substance.

Dr. S. G. Dabney (Tonsillotomy; Secondary Hemorrhage): I have a case to report which was not serious in its character, yet it looked at one time as if it might become troublesome. It was a case of secondary hemorrhage after removal of the tonsil in a lady twenty-five years of

age. The chief lesson in the case to me was to show how very difficult it might be to control severe hemorrhage under these circumstances. The tonsils were removed with the ordinary tonsillotome, one with Mathews' instrument, the other with Mackenzie's. No trouble was experienced at the time, although the tonsils were very hard and fibrous. Operation was done about 11 o'clock in the morning; the patient went home, and in the afternoon of the same day, probably about 5 o'clock, the right side began to ooze a little blood. I was sent for, and the bleeding was not really serious enough to be alarming, but quite troublesome. I made application of the usual styptics, but found that even the tanno-gallic acid mixture produced such nausea that its use could not be continued. I have generally found that this mixture would effectually control hemorrhage in this locality in a very short time. In this case I found that the application of a mop of any kind, with or without medicine, would produce such violent retching that it had to be discontinued. As the bleeding was not dangerous and there were no symptoms that were really alarming, I confined my treatment to hypodermatic injections of morphine to give the patient perfect rest, and the use of ice, held in the mouth and applied to the neck. A half grain was given in two injections. I simply report the case to show how inefficient are the ordinary means of controlling hemorrhage in this situation; how difficult pressure is, and how ineffective styptics are in such cases.

In looking up the literature of the subject I find authorities differ very widely in regard to the best methods of removing tonsils in the adult. Of course in children the operation is very simple, and serious hemorrhage in a child is almost unknown. But in grown persons, where the tonsils have become hard and fibrous and where the tendency of the vessels to contract is thus prevented, it becomes a more serious procedure. Many authorities therefore recommend that the snare should be employed and the tonsil removed very gradually. This method is very tedious and the operation is painful to the patient. I refer to the cold wire snare. Many surgeons use electro-cautery snare. The objection to this method is that it leaves a burned surface in the mouth, which is very irritable and not easily healed. One case of serious hemorrhage is reported after use of the electro-cautery snare. Knight, of New York, has recently written quite an elaborate paper on this subject. He advises in every case that unless there is some hemorrhagic diathesis it is wisest to use the smooth tonsillotome. A great

many devices have been recommended for stopping hemorrhage in these cases if any occurs, but they are all very difficult of application and inefficient. I have never had any serious hemorrhage, and would like to know what the experience of others in this branch of work has been. It has been my custom to use the tonsillotome in almost all cases after excluding as far as possible any chance of hemorrhagic diathesis. I have operated often in both adults and children by this method, and this happens to be the first case of even threateningly serious hemorrhage in my experience.

DISCUSSION.

Dr. Bailey: What would be the objection to employing a styptic, for instance, like Monsell's solution?

Dr. Dabney: Whatever styptic you use upon a sensitive throat produces so much gagging and the patient is so intolerant of it that the local application seems to have very little effect. Hemorrhage in these cases, when it is severe, is more apt to be secondary than primary. Hemorrhages that come six or eight hours after the operation are more liable to be serious than before.

Dr. Cottell: I remember assisting Dr. Palmer some years ago in removing a tonsil from a young lady; secondary hemorrhage came on, and it was frightful, the amount of blood was enormous. He succeeded in stopping it, if I recollect correctly, with persulphate of iron. The operation was done with a tonsillotome.

Dr. J. M. Ray: I reported a case two or three years ago to this Society where, under anesthesia, with a guillotine I removed a tonsil from a young lady, in which I had troublesome hemorrhage. I left her doing well, and went to make another visit in a distant part of the city. Considerable bleeding took place after several hours, and as I could not be reached Dr. Cheatham was called in and worked with the patient for several hours before the hemorrhage was checked. I saw the patient again afterward and she was very weak, having to remain in bed three or four days.

The most serious case of hemorrhage I ever had after tonsillotomy was in a medical student with a very fleshy, thick neck. He had an enlarged tonsil, which I cut out at my office; immediate bleeding was very slight. After the operation, as there was some little oozing, I told him to sit in the office and keep quiet for a short time. Presently some one called me to the patient, he had fallen out of his chair on the floor. Nausea came on, and he vomited probably a quart, evidently the con-

tents of his stomach mixed with blood; he fainted three or four times. I tried to stop the hemorrhage by iron applications and by mopping out with tanno-gallic acid solution; the blood would clot, but even then it would ooze out around and through it. At last he reached a point where I had to do something, as the hemorrhage was becoming serious. I inserted my thumb into his mouth and pressed it tightly between the pillars of the fauces against the bleeding surface. This finally arrested the bleeding.

Dr. Cottell: What is the anatomy of the hemorrhage, is it dilatation of the vessels?

Dr. Ray: It occurs usually in adults where a large fibrous tonsil is removed; on account of the non-tractility of the tissue the vessels stand wide open. I have gotten to a point now where I very rarely cut out a tonsil in the adult without a good deal of uneasiness about it. Whenever I encounter large fibrous tonsils in the adult I use something besides the knife. In the last few years I have been using the galvano-cautery and Wright's guillotine. I removed a pair last spring, the largest I have ever seen, from a lady sent me from Middletown, Ky. They were very hard, firm, and fibrous, and I had no hemorrhage to amount to any thing. I have probably removed a dozen in the last year with Wright's guillotine and galvano-cautery, and have had no bad results.

Dr. Stucky: Have you ever seen any middle ear trouble from extension of the inflammation after tonsillotomy?

Dr. Ray: I have had patients complain of pain in the ear, but there has never been any suppuration.

Dr. Rodman: In place of entirely removing a tonsil in the adult, is it not a fact that if you take away half of it the balance will shrink up?

Dr. Ray: This is not always the case; where the tonsils are large and fibrous they will not do it. If the tonsil is cut half in two, just as many vessels are liable to be cut as though it were entirely taken off. If you cut all the fibrous tissue the vessels are more liable to contract than if you leave a portion of the fibrous tissue.

I have performed several tonsillotomies in which the patients told me it was the third time their tonsils had been taken out. I suppose simply the surface has been shaved off. I do not think a tonsil ever recurs after it has been once entirely removed.

Dr. Stucky: Two or three years ago, at a meeting of the American Rhinological Association, Dr. de Vilbliss, of Toledo, read a paper upon

the subject of tonsillar hypertrophy, in which he took the ground that it was never advisable to amputate a large fibrous tonsil in the adult, claiming that there were three dangers. The first and greatest the danger of primary hemorrhage; second, the danger of extension of the inflammation; third, the danger of secondary hemorrhage. Under the use of the guillotine I never remove a fibrous tonsil without considerable anxiety; in using the actual cautery in two instances I have had suppurative middle ear trouble follow from extension of the inflammation, and in one case secondary hemorrhage. Where we have large fibrous tonsils to deal with I believe very marked atrophy can be accomplished by use of the galvano-puncture. I have very little faith in the injection of carbolic acid. I have injected campho-phenique; but I believe that with the galvano-puncture you can accomplish more with less risk than by any other means of reduction now at our command. I would like to mention, concerning the relief of hemorrhage by accident, I was luckily able to control it in one instance by the use of saturated solution of iodine and tannic acid.

Dr. Cottell: I would like to ask if any of the Fellows know any thing about the use of electrolysis in this connection. I do not see why it might not be done very successfully with a powerful current and two large needles. By this method there would be no danger of hemorrhage.

Dr. Dabney: I take it that pressure in severe cases of hemorrhage following tonsillotomy would be more liable to be effective than any other means; but of course this would be very fatiguing to the surgeon. There is an instrument for that purpose, Clendennin's forceps. I thought after I had this last case, although it was not serious, I would provide myself with this forceps for the future, so that in cases of tonsillotomy in adults I would be ready for an emergency.

In regard to the different methods of removing the tonsil, I did not discuss that point in reporting my case. I suppose it is an established fact that there is less danger of hemorrhage in the use of the electro-cautery, yet one case of very serious hemorrhage has been known to follow this method. The only disadvantage of this mode of treatment, I believe, is the extreme sore throat which it causes and the danger of extension of the inflammation in the throat.

As regards ear complications, I have seen none amounting to sup-puration, but it is very common indeed that we have acute pain in the ear. Galvano-puncture is of course good treatment, but like electrolysis

it is very slow. With either galvano-puncture or electrolysis it will usually take many weeks to effect a cure, while with the other methods the operation is soon over.

Dr. Ray: The best thing I have tried outside of excision and galvano-cautery is saturated solution of chloride of zinc. This solution is put on a probe and mopped over the tonsil, also passed down into each crypt.

Dr. Dabney: Referring to Dr. Rodman's question concerning hemorrhage in these cases: In his paper Dr. Knight asserts that there is very much greater danger of hemorrhage if you only cut to the middle of the tonsil than if you sever it entirely. His explanation of it is that the fibrous tissue is more developed in the center of the tonsil than it is further down, and it is this which keeps the vessels open. It is my rule to excise as much of the tonsil as possible.

Dr. D. T. Smith ("Morphea Nigra;" "Migratory Tumor"): Among the patients I have exhibited before this Society in the last year or two one you will remember as a case of morphea nigra. I had opportunity a few days ago to see that case again. The mouth was giving some less trouble than when I brought the patient before the Society, but the spots on the skin were larger and more marked. The disease is much easier made out now than when the case was exhibited.

Another was a case of migratory tumor. About two months after this patient was brought before the Society the tumor disappeared entirely. The treatment was that which we spoke of at the time, tonic, strychnine, arsenic, and iron. The treatment may have had something to do with it, but of this I am unable to say positively. The tumor lasted four months after treatment was instituted. •

Dr. Cartledge (Pyloroplasty): At the last meeting of this Society I read a paper founded upon a recent operation (pyloroplasty) which I had performed. The man has done uninterruptedly well since that time, and is now taking all forms of food without any trouble and without any pain; his digestion seems to be perfectly normal, and he complains of no discomfort. The dilatation of the stomach is very much diminished at the present time; the area of the distension is much less, as so far the operation promises a great deal in the relief of the distressing symptoms. There is no discomfort an hour or so after eating, when we would expect the food to be passing through the pylorus. There is no evidence of trouble and no evidence of leakage.

DISCUSSION.

Dr. Rodman: I think this is certainly one of the most interesting cases that has been before the Society for years, and I hope when the patient is well enough Dr. Cartledge will exhibit him before the Society.

Dr. Cottell: I will report a case which illustrates how large a quantity of belladonna may be taken with comparative safety. A child three or four years of age had whooping cough. I prescribed one half ounce of tincture of belladonna, to be taken in small doses at certain intervals. The parents were careless enough to leave the bottle where the child could reach it, and she probably swallowed about three fluid drams of the tincture of belladonna. As soon as the family found out what the child had done they sent to the druggist, who said the medicine was deadly poison, and that they had better go for the doctor in a hurry. I was telephoned for, but could not be had, and the case was seen by a neighboring doctor. I do not know what he prescribed, but I saw the child several hours afterward and she was in very good condition. She was pretty red, and there was a good deal of tumultuous action of the heart, but her condition was such that I simply told the parents there was absolutely no danger. I did not suggest an antidote or any thing else. Some therapists recommend enormous doses of belladonna. You will find that Eustis Smith recommends a prescription calling for, I think, a half fluid dram of the tincture of belladonna at a single dose. But it is said that the English tincture is weaker than our American tincture.

Now a lesson may be drawn from this. Of course we know the tolerance of childhood to belladonna compared with the adult. This also brings up the question of the poisonous action of atropine, which I believe is a foolish bugbear. I was taught when a student that atropine was a very deadly poison. I do not consider it so; large quantities may be taken by an adult. It may produce some alarming symptoms, perhaps, but the cases nearly always get well; it does not kill as opium does.

No. 2. The patient was referred to me by Dr. E. R. Palmer; a man about forty years of age, suffering from a severe form of wry-neck, the spasm being clonic. I have never seen another case exactly like it. A puzzling feature to me is that I am not certain as to all the muscles involved. I have been able to locate the trouble in the sterno-cleido-

mastoid, the levator anguli scapulæ; then the deeper muscles of the side of the neck, such as the splenius capitis et coli; in fact there are many muscles concerned.

It is probable that the trouble is due to some central lesion, perhaps cerebral. There is no history of syphilis in the case. The patient is a gentleman in the better walks of life, is very intelligent, and I think would know if he had ever had syphilis. Of course it is possible that the trouble is owing to gummata; it may be sclerosis; may be some minute areas of softening over those portions of the brain which preside over the muscles involved.

I believe this case is chronic and incurable. There are other ways for accounting for this clonic spasm, but I am inclined to think that the trouble is central. I would like to know whether any surgical means have been devised for the relief of such cases.

DISCUSSION.

Dr. Cartledge: I only remember having seen one such case; that was a celebrated local case, occurring in a young lady several years ago. Some of the Fellows will doubtless remember seeing her. It was clonic spasm of the neck, right side, of the most persistent and distressing character. The spasm was continuous during waking hours, although during sleep there was entire relaxation and the head and neck would assume a normal position. The trapezius and splenius muscles were affected, also the sterno-cleido-mastoid, although there was a slight downward pull, the head making a rotary movement upon the shoulder. I saw this case in consultation with Drs. Wilson and Larrabee. The case was decidedly what might be termed neurasthenic; patient twenty-five or twenty-six years of age, and had always been looked upon by her physician as an hysterical woman. In this case I determined to resect a portion in continuity of the spinal accessory nerve. With that end in view, at the Morton Infirmary, without the proper after-appliances at hand, I made an incision and exposed the spinal accessory nerve. After doing this it was found that slight irritation of the nerve produced typical muscular contractions. The nerve was easily bared after passing through the sterno-cleido muscle, and nearly an inch of the continuity of the nerve was removed by excision. The wound was approximated and the patient placed in bed. I will state incidentally that, whether it was a coincidence of anesthesia or whether it had any thing to do with the case, the moment the nerve was severed there was a serious and

sudden heart depression exhibited by the patient; this was sudden, and so severe that for a time we were fearful of losing the patient. All the symptoms were immediately relieved after the operation. This improvement lasted for probably two or three weeks, when we noticed a little twitching which grew worse and worse until her condition was the same as it was originally. There was clearly a reunion of a nerve after nearly an inch of its continuity had been entirely removed. After this the patient passed out of my notice. Subsequently, I understand, Dr. Vance performed a normal ovariectomy upon this patient, removing both ovaries, which, however, failed to relieve any of the symptoms. There was absolute cessation of all symptoms after the neurectomy until there was evident reunion of the nerve, when all of the original phenomena returned. It is the only case of the kind that I have ever seen, and I think is one of great interest.

Resection of the nerve for forms of torticollis involving the posterior muscles, the trapezius and the splenius, has been performed many times, and has always been followed up with some mechanical support. It is an extremely successful operation in the cases that have been reported. This is the only case of the clonic variety that has come under my observation, all the others having been a tonic contraction of the muscles. I looked upon this case as being central trouble. There was no history of syphilis that we could elicit, although the patient, I understand, had been subjected to anti-syphilitic treatment.

Dr. Larrabee: There are some features in regard to the case reported by Dr. Cartledge that it would be well for us to consider. When the case came under my observation I thought it was chorea, and was very much surprised when I heard that the operation of ovariectomy called normal by Battey had been performed for her relief. I still believe the trouble to have been of central origin.

There is one point which I wish to emphasize in regard to the operation done by Dr. Cartledge upon the patient in question. At the moment of division of the nerve the heart suddenly ceased to beat. I sprang to her relief with a syringe which had been previously loaded with nitroglycerine and digitaline, and after an injection the heart again started.

Dr. Bailey: Such things occur under anesthesia without the division of a nerve, as all those who are familiar with anesthetics know.

I wish to speak briefly in regard to the case reported by Dr. Cottell. In the first place tinctures are very uncertain as to their strength. In

this case it is very uncertain as to how much belladonna the child swallowed. I do not think it could be regarded as proof that this child took so many drams of the tincture of belladonna ; it would be very uncertain guessing to state that this child was poisoned by so much belladonna. I do not think we could do it, as there is no positive evidence. While it is possible that such a dose was taken by the child, yet it is not in proof, and we could not go to work to establish such a tolerance of belladonna by this administration of the drug. If three drams had been administered to this child by Dr. Cottell, or by any one else in whom he had confidence, and then the symptoms had been only so grave, it would have been something as to the effect of belladonna. Certainly I would say that this drug often by the stomach is not very efficient. It may be, on account of the condition of the patient, there is some change in the active principle of the belladonna, so that often by the stomach it does not give us the results we expect. I am prepared to say that oftentimes infants will take almost adult doses of belladonna without toxic influence, and I will again (if I have already done so) be put on record as having given hypodermatic injection to a child two weeks old one four-hundredth of a grain of atropine, repeated at different times. I saved the same child at six months old in a collapse from cholera infantum by hypodermatic injections of almost adult doses of atropine.

Dr. Smith : It is remarkable how few cases of poisoning by belladonna have been reported. It is true alarming symptoms sometimes occur, but the fatal cases are few. I remember having seen one case where a woman attempted to commit suicide by taking tincture of belladonna. Forty-eight hours afterward there was a threatened condition of heart failure, but the patient recovered. Although we often feel very uneasy from the effects of even small doses of atropine, or apprehensive of the poisonous effects of belladonna, the fatal cases are fewer than one would suppose.

Dr. Larrabee : What are the approaching symptoms of heart failure by belladonna ?

Dr. Smith : Rapid and weak action of the heart.

Dr. Cottell : The remarks made by Dr. Cartledge in regard to the second case reported by me are extremely interesting and lead me to hope that there is a surgical solution of the problem. It is a little singular that we should have associated belladonna poisoning with this case. Of course it is not in proof, as Dr. Bailey says, that the child referred to

swallowed any thing like two or three drams of the tincture of belladonna. While it is not absolutely proved, it is pretty certain that the child did get more than a dram. But to revert back to the other case: Drs. Larrabee and Cartledge have both stated that when the spinal accessory nerve was divided, in the case they mentioned, there was noticed a very peculiar depressing effect upon the heart. The cardio-inhibitory fibers through the spinal accessory and pneumogastric affect the heart and also the respiration, and the division of this nerve is liable to shut off respiration if not the circulation. The spinal accessory nerve physiologically antagonizes respiration; but belladonna paralyzes this inhibition, and in the case above a dose of belladonna would have doubtless forestalled the symptoms of cardiac depression which gave the operator so much trouble.

A NEW METHOD OF CUTTING ESOPHAGEAL STRICTURE.—Abbe (reprint from the Medical Record, February 25, 1893,) describes a new method of dividing cicatricial stricture of the esophagus, which he practiced with very good results on a patient aged thirty. After the performance of gastrostomy, a digital examination is made of the lower esophageal orifice, and a small conical gum-elastic bougie is guided into the canal by the finger. A string of heavy braided ligature silk is carried from the stomach to the mouth by passing a very small bougie through the esophageal stricture. In the case reported by the author the upper end of the string was brought out by the neck through a wound which had been made in an unsuccessful attempt at external division of the stricture. A larger bougie is now passed from the stomach along-side the string, and pressed tightly into the stricture so as to stretch it. The string is now drawn upward by the fingers, passed to the back of the patient's mouth, and the bougie will be felt to advance at once as the string makes its way into the tense stricture. Larger bougies are now passed, and the string is "seesawed" upward and downward. When the largest size has been passed, a rubber tube of corresponding size is drawn through the esophagus past the point of stricture, its lower end remaining outside the wound in the stomach. A smaller tube is passed into the stomach for nourishment. The patient can thus drink water for refreshing the mouth, and swallow saliva without contaminating the wounded surface, which the tube also serves to keep dilated. The large tube may be removed on the second or third day, and dilating bougies be introduced by the mouth after the fourth day. Finally the gastrostomy wound may be closed, whenever the patient has gained strength, by a plastic operation.—*British Medical Journal.*

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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THE DISTINCTIVE TITLE.

The British Medical Journal has opened its columns to the discussion of the question, "To whom shall the title of 'Doctor' be applied," and in its issue of October 21st the views of a number of English medical men are duly set forth.

In England, as in other foreign lands, the great art of healing is seldom if ever essayed in its entirety by one and the same man, and so titles or initial letters descriptive of the Medicus's attainments appear properly after his name. Thus we often see M. B., M. D., F. R. C. S., F. R. C. P., etc., decorating the names of those who heal the sick under the sanction of the laws of England.

The M. D., for instance, does not aspire to surgery, and the F. R. C. S. does not treat non-surgical affections. The M. D., in accord with his degree, would like to be called "Doctor," while the F. R. C. S. is content with the title of plain Mister until his achievements shall cause the powers that be to elevate him to the rank of Knighthood, when he will be indemnified for his patient waiting by the high-sounding title of "Sir;" but the M. B. and the unregistered M. D., while coveting the distinctive pseudonym, can not by law assume it.

It appears that there is in England a Medical Defense Union, which has been established for the purpose of maintaining the rights of those whose titles are encroached upon by the unprincipled appropriators of

other people's prerogatives. To this organization some of the controversialists appeal for justice, while others hint that the life of the society depends upon its maintaining in the matter a most discrete conservatism.

In brief it seems that the English surgeon does not want to be called "Doctor." The English physician, who by merit has won a place upon the register, wants to monopolize the title, so far as it applies to those who practice the healing art, while the M. B.'s and unregistered M. D.'s, who are justly called physicians, claim or usurp the right to place "Doctor" upon their cards and signs.

We append a few excerpts, which will give our readers a fair view of the way they see things on the other side of the sea :

J. L. C. writes: . . . In the first place I should like to ask who it is that gives the physician and surgeon the title of "Doctor?" The patients and the public are the criminals. When a person is ill he does not say, "Go and fetch the M. R. C. S. E.," but says, "Fetch a doctor;" and when the medical man arrives he is called "Doctor." If your correspondent will take the trouble to look at Nuttall's Dictionary he will find that such language is quite correct. Nuttall says "doctor" means "a learned man," "a physician," "*a fish with sharp-edged spines near the tail*," etc. It has been the custom from time immemorial to call physicians "doctors," and I hope it will continue. . . . If a medical man puts M. D. after his name when he is not entitled to it, he ought to be punished; but when a medical man puts "Dr." before his name on his card or doorplate, it is only to show that he practices medicine. A great many men holding an M. D. degree will not allow themselves to be called "doctor," simply because they do not practice medicine, but surgery. Perhaps "M. D. and M. B." would prosecute them for calling themselves "Mr.'s." "M. D. and M. B.'s" remarks about raising the status of the profession and improving general education are quite uncalled for. I have known M. D.'s of British universities no better educated than board school-boys, and altogether deficient in gentlemanly manners.

A registered M. D. (registered as such in the first Register issued) writes: As to the title of "Dr.," which is now being used by a large number of practitioners, not only on their doorplates but also on their cards, without being legally entitled to adopt the title, the time has arrived that such illegality should be discountenanced, particularly after the opinion expressed a short time since at the High Court that no one unless a registered M. D. can style himself "Dr.;" also with two-penny dispensaries and usurpation of a title to which the majority of medicals are not entitled, thus assuming a false position in the estimation of the public. Why do not the different colleges—who do not grant degrees, merely qualifying diplomas—exercise their authority in the matter and not allow their members and licentiates to

palm themselves upon the general public as doctors? Even the licentiates of the College of Physicians, London, are styling themselves "doctors," contrary to the by-laws issued by that college. The College of Physicians, Edinburgh, seems to have been the first aggressor in permitting their licentiates to use the title—especially in the year of grace when their diploma was to be had by the payment of £10. . . . As now constituted there are: Doctors—that is, doctors of medicine, M. D.'s; physicians of a college of physicians and surgeons; ditto surgeons. At present L. S. A.'s are without title, some of whom are now styling themselves "doctors."

Common Sense writes: An M. D. holding important posts and in good practice would scorn to interfere with his more humble neighbor, because he found it simpler, more convenient, and less conspicuous to have a small doorplate with "Dr. So-and-So" on it, and how can this touch the interests of those M. D.'s who complain of it? They can put "John So-and-So, M. D.," and what more can they want, and what can possibly show more their great superiority over their more humble brother?

Again, it is but an act of selfishness on their part, for if they use their magic letters they can not use the title "Dr." with any decent taste, and if they use this title they must drop the letters. It seems to me the whole matter is contained in a nutshell, and is a question of success or non-success. . . . An improper assumption of titles is greatly to be deprecated, but it is no more an assumption, in my opinion, to use "Dr." on a doorplate by every qualified doctor than it is for every minister of religion to call himself "Rev."

F. W. C. writes: There is little doubt that, were the general public educated in this matter as regards the intrinsic worth of the variety of medical titles and the various standards required by the different universities and colleges, there would be no hardship for many practitioners to be called "Mr." But as the public is so uneducated on this subject, and so imbued with the idea that a physician or surgeon must necessarily be a doctor, it is a great hardship to well-qualified men who have passed, it may be, a higher standard of examination than men holding an M. D. degree, to be considered their inferiors from a professional point of view. . . .

M. D. and Physician writes: Would it be considered peculiar or incorrect for the I. or M. R. C. P. to place on his doorplate "Physician" after the name, omitting "Surgeon," if not practicing as such? If correct, that would settle the dispute about the title of "Dr." (one used by some M. R. C. P.'s as a right, others by courtesy), provided that the M. D.'s do not usurp the right to the title of physician, a far more respectable and highly-thought-of address than the other, which is too often mixed up with the retail of lollipops, tooth brushes, quack medicines, and consultations, medicines included, at the charge of 6*d.*, or clubs at 2*s.* 6*d.* a head. Physicians are not permitted to do so. Such conduct is more damaging than the misuse of titles.

Dr. A. Sheen (Cardiff) writes: I would solve this question in the following manner: Every registered medical practitioner should have the right to style himself a "doctor," just as every lawyer is styled a "solicitor." This would not imply that he was an M. D. He should put on his card or his plate—

Mr. ———,
Doctor.

The public calls us "doctors," but in print we are spoken of as "medical men," "medical gentlemen," or "medical practitioners"—absurd titles; as is also the one which we frequently see on a doorplate, namely, "Physician and Surgeon." . . .

H. R. writes: I have often noticed that M. D.'s describe themselves on their doorplates as "Dr. —, Physician and Surgeon." Strictly speaking, they are doctors of medicine and surgery, and have no more right to describe themselves as physicians than a licentiate has to describe himself as M. D. They will answer, "An M. D. is a physician." I say he is not, unless a physician or licentiate in medicine is a doctor. Your correspondent wants to gain the advantage of his M. D. and at the same time claim the diploma of physician without earning it. If a degree in medicine were only granted to B. A.'s, as in Dublin, then the graduates might be justified in feeling pride in their knowledge of general literature, but the B. A. is not generally compulsory. "M. D., M. B." suggests that the Medical Defense Union should take the matter up and proceed against physicians who call themselves "Dr." May I conclude by asking how long that society would last if it followed this suggestion.

To us on this side of the sea, who hear the title of "doctor" given to anybody in any way associated with medicine or medicines, from the most eminent and venerable physician to the drug clerk who mixed his first prescription yesterday, the "game would not seem worth the candle."

One of the above writers quotes, as one of the definitions of the term "doctor," "a fish, with sharp-edged spine near the tail." Webster, after giving the classic use of the term, calls a doctor: "One duly licensed to practice medicine; a physician; one whose occupation is to treat diseases." He also calls a doctor a "mechanical contrivance to serve some purpose in an exigency," for instance, "an auxillary steam-engine, called also a *donkey* engine." And we are all familiar with the colloquial use of the word in the verb transitive as applied to the adulteration of liquors and foods, and the surreptitious tinkering of election returns.

These considerations and many more would seem to make it advisable for the physician and surgeon to drop the term so far as practicable,

contenting himself with the title of plain Mr. like other folks. Of course the public will continue to call him doctor (sometimes "Doc."), but there is no good reason why he should continue to apply to himself a term so degraded and deflected from its original high uses as to have for him no longer any distinctive merit.

Notes and Queries.

TO THE MEDICAL PROFESSION OF KENTUCKY. —At the semi-annual meeting of the Southwestern Kentucky Medical Association, held at Dawson, Ky., October 3, 1893, the undersigned committee was appointed to correspond with the medical profession, asking aid for Dr. A. Calloway, of Eddyville, Ky.

Achilles Calloway was born in Bedford County, Va., January 27, 1814. His parents, Achilles and Elizabeth Hudson Calloway, came to Christian County, Ky., in 1818. They were devout Christians and members of the M. E. Church, and the parents of eight children, of whom the subject of this sketch is the youngest. The father died in 1841; the mother in 1853. Achilles, jr., attended school until sixteen years of age, when he left home and worked at various mechanical employments until twenty-five years of age, when he began the practice of medicine, having studied medicine for six years when not engaged in his daily avocation. After ten years' practice he went to Paducah, where he accepted a position in the U. S. Marine Hospital, where he served under Presidents Pierce, Buchanan, and Lincoln. He returned to the Tennessee Rolling Mills in 1866, where he practiced his profession until he removed to Eddyville in 1882. Dr. Calloway has always been regarded as an able and honorable practitioner. He practiced with brilliant success in the cholera epidemics of 1849-50-51-66-73. Through the infirmities of age he has been unable to do active business of late, and his liberal disposition and leniency toward his patrons has prevented the accumulation of sufficient means to sustain him in his declining years, and he is thus reduced to penury. We commend him to the profession not as a pauper, but as a fellow physician in distress, whose chief misfortune is liberality, and whose principal weakness is kindness to his fellow-man.

He is a member of the Southwestern Kentucky Medical Association. He is now dependent upon his county and the citizens of his town for life's sustenance. Any thing you may feel disposed to contribute to his support should be forwarded to

PADUCAH, KY., Oct. 23, 1893.

P. H. STEWART, M. D.

Secretary S. W. K. M. A.

SALOPHEN IN ACUTE RHEUMATISM.—Hardenberg reports ten cases of acute rheumatism treated with salophen, and sums up his observations as follows: "A fifteen-grain dose every three or four hours for twenty-four hours is frequently sufficient. In no case was there observed any toxic effect or gastric or aural irritation. The average febrile period was but six days, and the average total stay in the hospital but ten days. The pain was quickly relieved and no cardiac complications followed." These conclusions are in all respects in accord with the observations of Caminer and Froehlich and the later reports of Oswald and Koch, all of whom found in the pleasanter taste of the drug an advantage over the salicylates. In cephalalgia, pleurodynia, and some cases of trigeminal neuralgia marked relief was obtained from small doses. In the severer cases of acute rheumatism, however, the German observers looked upon salicylate of sodium as still the best remedy. Drasche and Hoischmann both report cases of the elimination of the drug by the skin in a crystalline form exactly like the crystals of the original powder. If this is true, it throws doubt upon the supposed splitting up of salophen into a salicylate and a phenol in the system. The remedy is best given in powder.—*Boston Medical and Surgical Journal*.

THE NEW YORK STATE ASSOCIATION OF RAILWAY SURGEONS.—The third annual meeting was held in the New York Academy of Medicine's building on Wednesday, the 15th inst., under the presidency of Dr. George Chaffee, of Brooklyn, in addition to whose address the program announces the following: A Dissertation on the Transportation of Persons Ill with Contagious or Infectious Disease, by Dr. G. P. Conn, of Concord, N. H.; The Duties of Chief and Local Surgeons, by Dr. G. J. Northrop, of Marquette, Mich.; The Railway Hospital, its Necessity and Benefits, by Dr. Frank H. Caldwell, of Sanford, Fla.; Unjust Verdicts in Civil Damage Suits, by Dr. J. S. Wight, of Brooklyn; The Influence of the Attending Physician in Litigation Cases, by Dr. M. Field, of New York; The Evolution of the Railway Surgeon, by Dr. R. S. Harnden, of Waverly, N. Y.; A Peculiar Result of an Injury, by Dr. C. M. Daniels, of Buffalo; Traumatic Ankylosis, by Dr. S. H. Manley, of New York; and Ophthalmology in Railway Surgery, by Dr. J. E. Weeks, of New York.

DR. KEELEY'S SUIT AGAINST THE LANCET.—The *Lancet* announces that Dr. Leslie E. Keeley, of "gold-cure" notoriety, has discontinued the suit for libel brought by him against the editors of that journal, and will be obliged to pay the costs.

PROFESSOR HELMHOLTZ.—The *Union Médicale* states that Professor Helmholtz was severely injured on board the steamer Saale on his recent return from America.

THE death of Sir Andrew Clark, of London, is announced as having taken place on Monday, the 6th inst.

THE
AMERICAN PRACTITIONER AND NEWS

"*NEC TENUI PENNÂ.*"

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NO. 11.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—*RUSKIN.*

Original Articles.

CANCER, ITS ETIOLOGY AND TREATMENT.*

BY W. L. RODMAN, M. D.

The unquestioned fact that cancer has been steadily and alarmingly on the increase in all civilized countries of the globe for the past twenty-five years justifies the great attention given the subject by modern pathologists and clinicians. A mere reference to all of the more important contributions on the subject during the last year would consume more time than is allowed me this evening. Naturally enough a majority of workers in this line have occupied themselves with the obscure question of the etiology of the affection. The goal was thought to have been reached quite a number of times during the past few years by as many enthusiastic bacteriologists. As long ago as 1887 Scheurlen announced with much positiveness that he had discovered the cause of cancer in a specific microbe. The last year has found Armand Ruffer insisting that the disease is due to "parasitic protozoa" discovered by himself and a co-worker. Between Scheurlen and Ruffer there have been many conscientious and able bacteriologists, the Russians being particularly active in this field, all trying to prove cancer due to a specific micro-organism. All have failed to convince the scientific world—most of them to convince any one else but himself.

So great an authority as Roswell Park, in a recent lecture, in which he reviews at length all the work of the bacteriologists, announces his

*Read before the Louisville Surgical Society, October meeting, 1893. For discussion see p. 437.

adherence to the microbic origin of cancer, though he admits that the germ has not yet been found.

I shall consider as briefly as possible those theories which have found more or less acceptance by the profession. In the first place it is proper to emphasize the fact that cancer is increasing in an uncomfortable way in every civilized country where systematic records are kept.

The reports of the Registrar-General of Great Britain show a steady increase in the number of deaths from cancer since 1864, so that in 1890 there were nearly double the number of cases per one million inhabitants that there were twenty-five years ago.

These statistics apply not alone to London, which city you are aware has long been given a bad reputation for cancer by many writers, but applies to the entire United Kingdom, England, Scotland, and Ireland, with equal force. Ireland, with a steadily diminishing population, furnishes yearly a greater number of cancer patients. Every country of Continental Europe shows the same steady increase on the part of cancer.

Dr. Walshe, in his famous work on cancer, as geographically distributed, remarks that tropical America is comparatively exempt from the ravages of malignant disease. Young concurs in this opinion. He says that negroes in the West Indies rarely suffer from cancer, and the isolated cases seen there are among the better classes whose habits are similar to the Europeans. Both of these authors wrote a half century ago, when methods of diagnosis were far from as exact as now, and their observations on this account lose something in weight. It will, however, be admitted, I think, that the negro population of our Southern States is, comparatively speaking, immune from cancer.

It is asserted, and apparently upon the best authority, that countries whose inhabitants show the highest state of culture and civilization furnish the greatest number of cancer cases. It is also a fact that cancer is practically unknown among savage races. Dr. Livingston, in his work, *Travels in South Africa*, says that the natives never have cancer, but do often have benign tumors, especially fibrous and fatty growths. A service of two years near one of the largest Indian Agencies of the West failed to develop a single instance of malignant disease in my own, or, so far as I know, in the practice of any of my colleagues.

Sex. It has long been recognized that cancerous growths are by far more common in the female than the male. Making ample allowance

for the greater number of women in the world, the difference is still striking. There are, according to the Registrar-General, one hundred men to one hundred and five women throughout England; yet cancer is twice as common in the female sex.

The difference, of course, is due to the well-known tendency of the breast and uterus of women to undergo malignant degeneration. According to Herbert Snow nearly one half of the cases of cancer in the female attack the breast and uterus. Of four hundred and sixty-seven females at the Cancer Hospital of London, in 1889, "one hundred and fifteen suffered from malignant disease of the breast," and "exactly the same number from that of the uterus." "Of two hundred and three males only four suffered from cancer of the genitals. With this may be contrasted a record of six cases epithelioma of the vulva." "Two women had malignant disease of the tongue, one ditto on the lips, none on the mouth and fauces."

"Among the men, on the other hand, we find twenty attacked by tongue (epithelioma), fourteen by the same in other parts of the mouth or pharynx, eleven by epithelioma on the lips, three by cancerous disease of the tonsils." "While seven males were attacked by epithelioma in the skin of the face, only one woman suffered thus; whereas six men had the same on the external ear—the record is blank on the female side." "One patient only (male) was treated for rodent ulcer commencing in the lower eyelid."

Women are only slightly liable to cancer of the tongue, lips, mouth, tonsils, etc., whereas men, according to Snow's figures, suffer frequently. My own and I believe the experience of every observant surgeon agrees with this. In a paper read before the Kentucky State Society at its Henderson meeting in 1890 I called attention to this fact.

To quote Snow further: "When, however, we pass to other regions of the body there seems to be almost a parity between males and females in respect of liability to cancerous developments. Eleven women and seven men suffered from cylindroma of the rectum; two women and six men from disease of abdominal viscera; five women and four men from disease of the extremities. The external genital organs in both sexes are pretty much on a par."

In Jessett's work on cancer of the alimentary tract he makes clear the greater frequency of cancer in pharynx, esophagus, and stomach of men. In thirty-five cases of cancer of esophagus and pharynx men suffered twenty-five, women ten times. While there is not so

great a difference with the stomach, still there is a preponderance in favor of males. Fox, Welch, Habershon, and others make this fact clear.

Below the stomach the number of cases are about equal in the two sexes. Of forty-two cases of rectal cancer reported by Jessett twenty were in men, twenty-two in women. Of one hundred and four cases of cancer of intestines, excluding the rectum, forty-six were in men, fifty-eight in women. Men are more liable to carcinoma of the bladder, larynx, and eye, scarcely at all liable to disease of the breast.

I have considered at some length the predilection of malignant disease for this situation, and that in the male and female respectively, because I consider it most important and as possibly giving us a key to the situation.

Points most exposed to traumatism, whether it be one sudden act of violence or long continued irritation, are parts most obnoxious to cancer.

Why are women so subject to cancer of the breasts and uterus? Is it strange when we remember these organs are in a continual state of artificial stimulation or irritation from the time of puberty until say forty, when physiological atrophy or devolution begins? Is it strange that organs which, as I say, are kept overstimulated by various and well-known causes for twenty or more years should, when they begin to decay or undergo devolution, do so rapidly and sometimes not in order? Is it not a law in nature that the quicker and more mushroomy a growth the speedier its decay? So, when the cells of the female breast or the uterus are undergoing physiological atrophy, is it remarkable that the epithelial tissues which are so inclined to run wild after forty should overwhelm and subdue the already enfeebled normal cell elements? Is it singular that a uterus which I saw to-day, the seat of an offensive epitheliomatous mass, should have become so eighteen years after childbirth, which left an ugly laceration of the cervix followed by endometritis, etc., lasting until the onset of cancer? We know that cicatricial tissue everywhere invites malignancy, and that many of the cases of epithelioma of the cervix uteri owe their beginning to a laceration. Now, *per contra*, why do men suffer so often from cancer of the lips (seventeen to one), tongue (ten to one), mouth and fauces (fifteen to one)? I answer, irritation. Women as a class do not use tobacco and drink spirits on the one hand, and they keep their mouths and teeth in good condition on the other, which keeps the mucous membrane in a healthy condition and enables it by its natural physiological resistance to withstand the encroachments of malignant disease.

It can not be doubted that smoking, chewing, and spirit drinking (especially in the undiluted form) constitute a valid reason for the increased number of cases of malignant disease in the male. Drunkards suffer often, the temperate much less frequently, teetotalers rarely.

Diet. It has frequently been claimed that diet had much to do with the causation of carcinoma. The delightful tomato has a particularly bad reputation. Then, again, vegetarians have been supposed to suffer with comparative infrequency, while meat-eaters were far more liable. Savage races live almost entirely upon meat, and yet they enjoy a remarkable immunity from cancer.

It is unlikely that diet has any thing to do with causing cancer beyond a most limited degree. That overindulgence in mustard, pepper, and other highly stimulating food may bring about a condition of mucous membrane which invites disease seems beyond question.

Climate. Haviland many years ago wrote a work upon the geographical distribution of cancer, and in this he asserted the fact that malignant disease was by far more often encountered in valleys than upon mountains, especially in valleys upon the banks of rivers which periodically overflowed.

A recent writer has advocated the same theory, and instances a certain neighborhood in Switzerland which has been noted for the number of cases of cancer it furnished.

The best authors discredit the geological theory.

Heredity. Until recently cancer was almost universally thought to be hereditary. This belief was founded very largely, no doubt, upon a mistaken pathology. As long as the constitutional origin of cancer was taught, a belief in its transmissibility from parent to offspring was most natural.

Now that it has been clearly shown to be primarily a strictly local affection there is no good reason for believing in its heredity. There is no good reason for believing that any of us start in life handicapped by a special liability to malignant disease.

Age. Age plays an important rôle in the development of cancer. It is rare before thirty. The two decennial periods of life, when it is most common, are from forty to sixty. This fact is not insisted upon as it should be by many writers. Lupus has often been mistaken for epithelioma, and this affection occurring so frequently in adolescents has caused much confusion. One almost never occurs after, the other prior to thirty. Lupus is pre-eminently an affection of youth, being

most common in impubic girls with blue eyes, fair skin, and light hair, while cancer is most obnoxious to advanced life, and so far as the face is concerned rarely occurs in women.

Nervous Theory. In his recent work Mr. Herbert Snow makes a strong plea for the nervous origin of cancer. He argues that in a healthy condition of the system, skin, mucous membrane, connective tissue, muscles, cartilage, and bone show no disposition whatsoever to encroach one upon the other, and that this order of things is due to the influence of the central nervous system which presides over the economy.

In cancer, he says, there is a local cell rebellion against the authority of the central system, and that it is the withdrawal of this normal presiding influence which makes cancer, an outgrowth of epithelial tissue, infiltrate and root out all surrounding tissues.

The frequency of cancer in highly civilized races, its infrequency among savages, its greater affinity for woman, the more impressionable of the two sexes, especially for her uterus and breasts, which are so intimately connected with the nervous system, are to him strong reasons in support of the nervous theory.

Snow also states that cancer is rare in the insane, unknown in idiots, which is further evidence in support of his theory. Any statement from Snow certainly comes from high authority, but it would be difficult for him to show conclusively that cancer is so rarely met with in insane subjects and imbeciles. Such at least does not seem to be the case in this country. I have received in the past few days letters from Dr. James Rodman, who was twenty-six years superintendent of the Hopkinsville Asylum, and from Drs. H. K. Pusey, B. W. Stone, and F. H. Clarke, the three present superintendents of our Kentucky Asylums, and none of them entertain the views of Snow. Snow also believes that cancer is often due to a decided mental impression coming on suddenly after grief and various kinds of trouble. Walshe, Paget, and others support this theory. One can understand how long-continued mental depression could bring about a condition of nutrition favoring the onset of any disease. It does seem most unlikely, however, that cancer enjoys a special distinction in this respect.

Admitting, if we could, that the nervous theory explains the great frequency of cancer in the female uterus and breasts, it utterly fails to give any satisfaction whatsoever as to the great preponderance of cases of malignant disease in the lips, tongue, fauces, pharynx, esophagus, and face of men. A "chain is only as strong as its weakest link."

Cohnheim's Inclusion Theory. Before leaving the etiology of cancer I must add that Cohnheim's inclusion theory goes far toward explaining the origin of many cases of cancer, as well as many neoplasms of the benign type. Undoubtedly neoplasms both benign and malignant are most often seen in situations where developmental faults are most likely to occur.

Treatment of Cancer. At the conclusion of his paper Dr. Rodman said: While my paper was limited to the etiology of cancer, I will, with the permission of the Fellows, occupy a few minutes in speaking briefly as to its treatment.

In the first place, I wish to plant myself squarely and affirm my belief in the curability of cancer. That all cancers are not curable is manifest, some pursuing an untoward course in spite of every thing which is done to stay their progress.

But, as cancer is strictly a local disease primarily, we are justified in expecting a reasonable number of cures should we begin treatment sufficiently early, before metastases have taken place, or, in other words, the disease becomes constitutional.

This fact, I am constrained to believe, is not appreciated as it should be by the profession, not at all by the laity. Too often are patients with cancer given some placebo, and advised by their family physician to postpone operation until, perhaps, the propitious moment for surgery has passed. Surgeons see too many such cases for the credit of our profession. Did the general practitioner appreciate the fact that operations for cancer of the lip give rather more than 38 per cent of cures—all of the cases passing the three years' limit without recurrence—Gross' and Banks' operations upon the mammary glands affected with cancer, as many as fifteen per cent of cures, etc., would surgery be withheld from these sufferers as it so persistently is in many instances? I think not. To avoid any possible mistakes in diagnosis on the part of general practitioners who do no surgery, and are therefore less interested in surgical than medical affections, let it be remembered as an axiom that every growth, benign or malignant, should be condemned to the knife at the earliest practicable moment. There are no exceptions. By adherence to this practice many lives will be saved, and the statistics of operations for malignant disease will make one of the brightest pages in the history of the achievements of modern surgery.

As optimistic as you may think I am in speaking of the good of early and proper operative measures in cancer, no one is more con-

vinced of the utter hopelessness and futility of delayed operations than am I. They do worse than no good; they often do positive harm, even in cases which recover from the primary dangers of the operation itself. Banks and others have demonstrated this. While it is some time since I read Butlin's most excellent book, I think I can quote him reasonably well, as what he wrote impressed me greatly. He says: "Battles, shipwrecks, and railway accidents are mild horrors when compared to many delayed operations for malignant disease." This language at first seems intemperate, but it is not so; and if any one thinks it is let him but investigate the history of operations for cancer of the kidney, stomach, larynx, and other organs when a diagnosis can not be made until the disease is beyond the reach of surgery.

They bring surgery discredit, and keep operable cases from seeking relief, giving the laity the impression that an operation for cancer is synonymous with death. As encouraging as operations on the superficial portions of the body are, it is questionable whether they have any reasonable chance of success when carried to the deeper and more vital organs, as sufficient tissue can not be sacrificed to prevent a recurrence, even though a diagnosis could be made early. Therefore, it is excellent surgery to close the abdomen when cancer of any abdominal organ has been diagnosticated, and not attempt the impossible.

Think of a surgeon amputating the mammary gland, cleaning out the axilla, excising the pectoralis muscle, resecting four ribs, amputating at the shoulder-joint, excising all of the scapula and part of the clavicle to cure a poor woman of carcinoma. It has been done, and, *mirabile dictu!* the patient lived four hours. Is this surgery?

As I have already occupied more time than I am allowed, I will speak briefly as to the method of operating before taking my seat. While I am not here as a partisan for caustics, I am here to say what I have said before in this and other societies, viz., that none of us possibly use them as often as we should. Their field of usefulness is necessarily more or less restricted, but when they can be used they are equal if not superior to the knife. Statistics show more cures to the credit of caustics than to cutting operations. The danger to life is also much less, for, in the first place, an anesthetic is unnecessary, and shock, hemorrhage, and sepsis less common after the use of caustics. Why then are they not used more frequently by surgeons. For no reason, I fancy, as much as the fact that they are so largely used by *quacks*. This outlaws them with many.

No one can read Bongard's work on caustics in cancer without being amazed at the wonderful results he secures by the use of his paste in the treatment of mammary cancer. Making every allowance for mistakes in diagnosis, his results are so much better than any other operator's that they challenge belief; still so careful a man as Butlin says, that when he first saw Bongard's book he was inclined to discredit it *in toto*, but after studying it carefully and writing him about his cases he brought himself to believe the remarkable results therein detailed.

His paste consists of chloride of zinc, arsenic, corrosive sublimate, and other substances made into a paste with wheat flour. Zinc is the principal ingredient.

In my own practice I have been partial to the officinal solution of the chloride of zinc, and, while it burns like fury, it gives excellent results. Michel's paste, or sulphuric acid and asbestos, is a most excellent application.

I have known four or five perfect cures of undoubted cancer brought about by the application of caustics. One particularly, a warm personal friend, comes into my mind as I speak. He was past fifty, a minister of the gospel, with an undoubted epithelioma of the lower lip when I saw him in the fall of 1882. I advised an operation by the knife, but instead he went to a neighboring city and had a noted quack burn it out. I am glad to say that he is in good health, serving his Master at this day.

I would not be considered a partisan for caustics over the knife in all or even a majority of cases, but I do insist upon their being given by surgeons the place they deserve. A man who uses either the knife or caustics exclusively is, like the anesthetist who invariably prefers ether to chloroform or chloroform to ether, wrong. It all depends upon the case.

Curetting a cancerous ulcer, a very common practice, is of questionable value—in truth no good can be shown to come of it.

Inoculation with the germ of erysipelas has in some instances had a modifying if not a curative effect upon the malignant growth. Coley, of New York, and others report such cases.

Medicinal treatment amounts to nothing. Herbert Snow, however, maintains that opium not only relieves pain, but undoubtedly retards the course of cancer.

CREDULITY OF THE MEDICAL PROFESSION.*

BY T. B. GREENLEY, M. D.

It is a common remark of medical men that there still exists among the people a great deal of superstition and an overweening amount of credulity. These remarks are usually the result of speaking of their faith in such things as the holy coat of Treves, the remedial virtues of the shrine of Lourdes, the faith cure as practiced by Christian scientists, as well as in the general use of patent medicines, wherein they take for granted the virtues they possess as asserted by the inventors without knowing any thing of the character of the ingredients they may contain. We all admit that this widespread faith and credulity exist among the people. But can we say that we as a profession are exempt from the same charge, though of course not to so great an extent as it exists among the laity. I now allude more especially to the fact that many of our most eminent men seem prone to take for granted as true any theory that may be advanced in the way of new methods, or new remedial agents in the management of disease, as well as the etiology of the same, without due consideration or investigation. At present I will only allude to a few instances of this character occurring within the last decade.

We all remember with what *éclat* Bergeon's method of treating pulmonary tuberculosis was announced, and that many able men in the profession accepted it as a rational plan. It was claimed that this treatment was in accordance with the antiseptic theory; that the sulphuretted hydrogen gas was absorbed by the bowels and eliminated through the lungs, where it acted as a germicide. It was also claimed that this fact was demonstrated by the odor of the gas made palpable to the olfactories by exhalation from these organs.

If the theory had been given proper consideration its fallacy would have been very apparent, as it was impossible for the gas to pass from the bowels to the lungs.

Then we had the Brown-Séquard plan, by which old people could be rejuvenated. Fortunately this vulgar fad was of but short duration. Yet while it lasted many of our big men practiced it with reported good results.

But the greatest furor yet produced among medical men on account

* Read at the May Meeting of the Kentucky State Medical Society, 1893.

of something new in medicine occurred when Koch announced a new remedy for the certain cure of tuberculosis. The world, in this particular, had never known such excitement, and for a while we all believed that the millennium for the salvation of a large proportion of the human family had arrived. We all remember how many cases were reported as cured by this wonderful treatment.

I acknowledge that I was greatly excited with the hope, on account of the high repute of its author, that a remedy had been discovered for the greatest scourge the human family is subject to. This hope, however, was of short duration, continuing only up to the time when Koch announced the character of its ingredients. As he claimed his bacilli to be the cause of the disease, and prepared his remedy from the bacilli and glycerine, I no longer had faith in it as a remedial agent for the disease. I think we have no instance in medicine wherein a cause of disease proves to be a remedy for the same. In this instance I regarded the lymph more in the light of a prophylactic than as a remedy, provided the tubercular bacilli cause tuberculosis. The position I occupy in this particular is well exemplified in the use of Jenner's kine-pox matter against variola, and Pasteur's diluted hydrophobic matter against hydrophobia. But it is well known that these agents would be of no remedial value in treating these diseases after development.

I will name a few more instances wherein our credulity has been exercised to too great an extent. It will be remembered that when Lister first instituted his antiseptic dressing in surgical operations it soon became to be essential, in the estimation of surgeons, for the safety of the patients in all operations. Some of his enthusiastic followers did not hesitate to announce that the least variation in the use of all of this paraphernalia, including the carbolic spray, was a dangerous omission, and that in case of accident or death the surgeon would be responsible and subject to damages for malpractice. But you know what a great change has come over even Lister himself in regard to his dressings. He has long since greatly simplified the proceeding and dispensed with a great deal of it. It was not long before he found the spray was injurious, and that the bichloride of mercury was irritating and poisonous. For years the rôle of operations was to use *antiseptic precautions*, now a majority of surgeons employ asepsis instead of antiseptis.

I think we are also somewhat credulous in regard to the etiology of certain diseases, and the manner in which the bacteria produce them.

We might refer to the cholera bacilli. The bacteriologists lay down certain laws by which this microbe is governed. (Ball's *Essentials of Bacteriology*, p. 107.) In the first place it does not enter the system by inhalation, but is swallowed, either with water or food, but principally the former; secondly, it can not live in acids; thirdly, it is never found in the blood, and fourthly, its seat of action is in the ileum at the site of Peyer's patches or glands. Now, if all these laws pertaining to the comma bacilli be true, they have a hard time in getting to the locality of their operations. It must be patent to the understanding of all that if they can not live in an acid medium their vitality would be hazarded in passing through the stomach; but, admit that this law is weakly stated, and that they finally do pass through this organ alive, they yet have a long road to travel. They must pass through the duodenum, jejunum, and far down into the ileum before they can go to work. But now comes the most singular part of the of the whole story, when we come to consider the physical character and properties of the bacilli themselves.

The comma bacillus is a small microbe, you might say several hundred times less than nothing, if we make a parity of its size to powers of natural vision, requiring several hundred diameters of the microscope to outline it. It is, of course, of vegetable origin, and possesses no inherent power of motion, being actuated altogether by extraneous forces. Then again, it is of course destitute of any power of differentiating any special locality where it should set up diseased action. Now it must be admitted that it is, in its passage from the stomach to the lower part of the small bowel, only moved by peristaltic action of the organs through which it passes, and is carried along the tract with their natural contents. Now, can any one imagine how the peristaltic movement of the organs is checked at the point of Peyer's patches so that the microbe may be separated from the alimentary contents and placed at the proper locality to commence work? If we believe the laws laid down by which this microbe is governed to be true, we must believe it to have consciousness by which it is guided to the place where it is to begin action. Then, again, we are informed by pathologists that the bacilli are found imbedded in the substance of Peyer's patches. Here is another puzzle hard to solve, as they possess no powers of locomotion, and, as before remarked, are only acted on by environment. If it was not for the law that these microbes are never found in the blood we could account for their presence in the substance of the glands above alluded to.

Now, when we take into consideration the laws laid down by which the comma bacilli are governed in their action in the production of disease and apply them to principles of reason and common sense, we must conclude that impossibilities confront us all the way through. In the first place, they could not traverse the stomach on account of the acidity of its contents. Then, again, how is peristaltic action to allow them to escape from the contents of the bowels and seat themselves in Peyer's patches low down in the ileum? And by what instinct or consciousness are they guided to this part of the bowel? Also, how do they force themselves into the substance of the glands?

We might further inquire into the pathology of the disease. It is known that in cholera the characteristic symptom is the rapid emptying of the blood-vessels of the serum of the blood, which is virtually the cause of death.

Now it seems very strange that the bacilli, admitting their presence in the substance of the glands, could produce the effect of inviting all the serum of the blood into the alimentary tract. In some rapid cases of cholera death ensues in a few hours from the development of the first symptoms. If the bacilli had been found in the blood we could more readily account for the symptoms.

Now, I think it will be admitted that it requires a considerable degree of credulity to believe all that is claimed for the comma bacilli as regards their action in the production of disease.

Pretty much the same history as claimed for the typhoid bacilli might be given.

The pendulum is allowed to swing too far to the left by many theorists as regards the cause of disease.

It is claimed that the pneumococcus is the cause of a large per cent of pneumonia, I think about ninety per cent. (Ball's Essentials of Bacteriology, p. 114.) Although this bacterium is a common inhabitant of the mouth, it never does harm unless there is some injury done to the pulmonary tissue; but it is not stated how it becomes cognizant of the fact, so as to leave the mouth and search for the impaired tissue and set up a stage of congestion. It may be that when a person is exposed to inclement weather, either cold or wet, thereby producing a partial stage of congestion of the lung, the microbe in the mouth by instinct passes into the air-cells and brings on the initial chill. By the same instinct it must be guided to the lung affected.

As a prophylactic against such a dangerous disease it would be

advisable to disinfect the mouth every day, especially during the pneumonia season.

But this microbe is credited with doing more work in the way of producing disease than it is entitled to, and in this respect nearly equals the *ameba coli commune*. It is credited with being able to produce, besides pneumonia, peritonitis, pleuritis, endocarditis, pericarditis, and meningitis.

As to the coli commune (Hohir and Councelman), it is charged with causing not only epidemic or tropical dysentery, together with all the same troubles due to the diplococcus aside from pneumonia, but also, wonderful to say, hepatic abscess.

But the most astonishing part of the history of its action is the manner or route of its getting to the liver. In leaving the colon it passes through the coats of the bowel, traverses the peritoneal cavity, and by differentiation makes its way up through the intervening tissues till it reaches the liver, where it enters and commences its work in forming an abscess, thereby changing its character to that of a pus microbe. If the author of this history of the functions of the *ameba coli commune* had claimed that it traversed the alimentary tract from its home, the colon, to the orifice of the common duct in the duodenum, he would have given it an easier route to the liver.

The accounts given by authors of the characteristics of certain bacteria are calculated to mislead the minds of their readers. It is stated (Ball's Essentials of Bacteriology, p. 18,) that some bacteria have the property of motion and are termed motile. This would lead us to think, perhaps, they were of animal origin and possessed of locomotor organs. Some varieties are spoken of as passing over the microscopic field quite rapidly. Again they are represented to possess all the functions of animals: "They breathe, eat, digest, secrete, and excrete."

Then again we are bewildered by the contention among bacteriologists as to the true microbe producing a certain disease. For instance, pneumonia is claimed (Ball's Essentials of Bacteriology, p. 111,) as the result of the action of two or more different microbes. Frankel, Friedlander, and Weichselbaum claim to have found several in this disease very similar to each other.

There are some ten different microbes so much alike in form that they can not be distinguished from each other; eight of them are found in Asiatic cholera, one in old cheese, and one in disease of chickens, and are very similar in their characteristics. When introduced into

animals under certain conditions some of them destroy life. (See Dr. Cunningham's Report, Calcutta.)

We have an account of a very singular phenomenon occurring in the history of the bacillus of symptomatic anthrax. On examination of a guinea-pig destroyed by injection with this microbe, it is stated that the bacilli are found in the serum but not in the viscera until some time after death. It would be a curious problem to solve how they reached the viscera after the circulation ceased.

In speaking of germicides, authors seem to regard heat as the most certain to destroy the vitality of micro-organisms. It is claimed (Ball's Essentials of Bacteriology, p. 22,) that spores of many varieties withstand very high temperature—some requiring 140° C., equal to 284° F., several hours for their destruction.

Why is it that spores resist the application of high temperatures better than the bacilli of which they are the offspring?

We know of no vegetable germ or seed but its vitality would be destroyed in a very short time by a much lower temperature. For instance, if we were to apply a temperature of say 250° F. to mustard seed for an hour, its vitality would perish, and we must conclude its shell or capsule must be as impervious to heat as that of the newly developed spore. A great many things are claimed in the history of microbes that greatly tax our credulity. We are taught to believe that in the microbe itself there is no harm, but in its products. After a short time it secretes a poison termed toxin, or toxalbumen, which produces its characteristic disease; and, again, in a shorter or longer time it secretes another principle termed antitoxin, which neutralizes or sets aside the poisonous action of the toxin or tox-albumen. This, of course, is intended on the part of the bacilli to cure the disease, but unfortunately, in most instances, they come to the rescue of their host with the antidote too late to save the patient. It would be a wonderful thing, and a great help to the doctor, if they would secrete their antitoxin a little earlier in the disease. On this principle it would be a grand thing to cultivate microbes and preserve their antitoxin secretions for remedial agents.

We now present some instances of credulity on the part of medical men which transcend any thing in this line heretofore mentioned, but I am glad to remark that this character of credulity does not pertain to a very large extent to our own profession. I allude to the method of treating diseases on the plan of *similia similibus curantur*. In the

first place we must exercise a great deal of faith in the preparation of the remedies. This more particularly applies to the virtues they derive by trituration and succussion than to the quantity of medicine given.

We must believe that by trituration and dilution increased dynamic force is imparted to these remedial agents; that a thirty-per-cent dilution properly triturated and succussed possesses more remedial virtue than any stronger preparation or dilution below it. But a great deal of its virtue depends on the time required in trituration and the number of shakes it receives. Then again, we are asked to believe that if these medicines have received the proper dynamic power by proper dilution and preparation they will exert as favorable an effect on the disease by olfaction as if administered *per os*. But if we can manage to comprehend and believe all this, we may be headed off when we come to study the manner of curing disease. According to the rule, in order to eliminate the existing or natural disease, we must produce one similar to it, and then assist nature to destroy the one we have produced. It would seem to us, if we could see it in that way, that it would be better both for the doctor and the patient to assist nature in the outset to get rid of the first disease, because if one similar to it is produced it results necessarily to the detriment of the patient and gives much more work to the doctor.

Now, our side of the profession is charged with practicing allopathy—that is, *contraria contrarius curantur*, which implies to produce a disease of a different nature in order to set aside or cure the existing disease. Of course we disclaim to recognize the cognomen, allopathy; but if guilty, as charged, we should make as short a job of a case of disease as our friends on the other side, because, instead of producing a disease in the system similar to the one existing, we would produce one contrary and of a much milder form, which with a little help from nature we could easily eliminate. But we regard it the best and shortest plan to aid nature to cure the disease we find the patient troubled with.

“To borrow Folly’s cap and bells,
Though Wisdom oft descends,
Yet Folly to her cost doth find
That Wisdom never lends.
That Wisdom hath oft played the fool,
Is seen in every age;
But here the bargain ends, for ne’er
Hath Folly played the sage.”

Reports of Societies.

THE LOUISVILLE SURGICAL SOCIETY.*

Stated Meeting, October 9, 1893, Dr. A. M. Cartledge, President, in the chair.

Dr. W. L. Rodman (Malignant Disease of the Antrum): This lady lives in Indiana, and came to this city to consult Dr. W. H. Wathen, having been referred to him by a patient of his. The trouble being out of his line, the patient was referred to me. She is fifty-two years of age, and has had a growth on the right side of her face for rather more than a year. She has had a great deal of pain for the last six or eight months. She has lost, she says, a good deal in weight, although she has not been weighed. Appetite is good; suffers a great deal of pain, and now is not able to open the mouth at all. I would like to have the Fellows examine her carefully, and discuss the case afterward. You will notice there are two enlarged glands in the right submaxillary region. A dentist, thinking that there was disease at the root of the tooth, bored into the antrum, obtaining nothing, however, except a little fluid. The question is, what is the diagnosis and what should be the treatment?

DISCUSSION.

Dr. A. M. Vance: I think the trouble is more than likely sarcomatous in character. So far as treatment is concerned, I have often expressed my opinion about work upon the upper jaw, particularly when the disease is as far advanced as this seems to be. I believe it would be impossible to remove all the tissue involved, and rather think the case is inoperable.

Dr. J. M. Mathews: I concur in what Dr. Vance has said in regard to the diagnosis and treatment.

Dr. Wm. Cheatham: I think it is sarcoma probably involving the antrum.

Dr. W. O. Roberts: I came in as the patient was going out of the door, and from the casual examination I made I should say it was certainly a malignant growth, and if there are no glandular enlargements I would advise its removal.

Dr. W. C. Dugan: It does not impress me as one of those cases of

* Stenographically reported by C. C. Mapes.

tumor of the antrum. The fact that there is no obstruction to that side of the nose is rather against it, as most of these cases encroach upon the nose before they cause as much discomfort as is evidenced here. I am inclined to look upon it as subperiosteal, and believe it is operable.

Dr. A. M. Cartledge: This to me is a very interesting case, and I am not at all satisfied in my own mind as to the diagnosis. First of all, I think I detect deep in this tumor fluid, and believe you will find fluid in the antrum. I saw once a case of sarcoma beginning in the antrum as a cyst. There was a large amount of dark colored fluid withdrawn from a perforation of the orbital plate of superior maxilla, and the tumor was found to originate in the antrum. The man died with destructive sarcomatous process of the whole upper maxillary region. While I believe there is fluid in this tumor, there are solid particles as well. I am not satisfied altogether that it is malignant. As a rule we do not have early infection of the lymphatic glands in the superior maxillary region. I should certainly cut into it and make a thorough exploration. You might find a cyst of the antrum inflammatory in character. The diagnosis does not seem to me to be certain, although I lean toward the fact that it is probably malignant in character. I would make an incision, and if the evidences are more or less conclusive of malignancy I would then remove the bone. It seems to me to be a favorable case for operation. As far as the local extension of the disease is concerned it is about as good a case in this line as we could find. Of course I would strongly suggest, if it is found to be malignant, the removal of these enlarged glands in the neck at the same time.

Dr. Vance: Is it not more than probable that other glands over the whole body are affected if there is gland involvement on the opposite side as a result of the growth?

Dr. Rodman: I do not detect any enlarged glands on the opposite side. There are two glands slightly enlarged on the same side as the tumor. However, these are very small, about the size of a hazel nut.

Dr. Dugan: I believe the enlargement of the glands will be found to be purely sympathetic, and there may be no infection at all.

Dr. Rodman: I do not detect any enlargement on the opposite side, but there are two enlarged glands on the affected side which have appeared within the last four or five months, as well as the patient can remember. I do not think there is any thing obscure about the diagnosis of the case. The appearance of the woman suggests malignant

disease; the fact that she has lost so much flesh, suffered pain in the way that she has done, indicates very clearly the malignant nature of the case. Leaving this case entirely out of view, when you consider neoplasms that are liable to occur in this situation it makes the chances three out of four that it is malignant. Less than two years ago, at the meeting of the Kentucky State Society in Louisville, I read a paper upon tumors of the upper and lower jaw, and at that time I went over all the statistics that had been gathered on the subject in every language, covering more than five hundred cases reported by Billroth, Butlin, Weber, Gurlt, Gross, and others who have reported the largest number of these cases, and I find that 76.3 per cent are malignant, the majority of such cases being sarcomatous rather than carcinomatous. This leaves but 23.7 per cent for benign tumors in this situation. Of these, 8 per cent are cysts.

Now, while there may be apparent fluctuation in the tumor before us to-night, still I think the chances are against the existence of fluid. In the first place, we know that it is not unusual to find deceptive signs of fluctuation in malignant growths. Especially is this the case in those of a sarcomatous nature. It is very common indeed that you find fluctuation just as clearly as any thing can be established, yet when you cut into the growth no fluid is discovered. This is a peculiar condition characteristic of sarcomatous disease. I do not think there is any fluid in the tumor under discussion. I believe that the trouble began in the antrum, and evidently existed for some months before there was any appreciable swelling. The woman had pain and other symptoms indicative of malignant trouble before any enlargement was appreciable. So I believe, to sum up, that this is a growth of the antrum. I think it is unquestionably malignant. The age of the patient and the fact of the involvement of the neighboring lymphatic glands would indicate carcinomatous rather than sarcomatous change, though I admit the greater frequency of sarcomatous disease in this situation.

As to treatment, I must say that I have never believed much in operative measures for malignant disease in this situation. Butlin reports one hundred and eight cases of malignant disease of the upper jaw which were operated upon, and only five out of the one hundred and eight passed the three years' limit when a supposed cure is effected. He states, furthermore, that the primary mortality from this operation is more than thirty per cent. It is much greater than any one would be prepared to believe without a careful study of the cases on record.

This mortality includes death from hemorrhage, shock, sepsis, etc., so that in cases of this kind where we have to face a certain mortality of thirty-three per cent from the operation itself, and you couple with that the fact that we can promise very little in the way of prolonging life, it is questionable whether operative steps should be undertaken. I confess that I have never seen any good come from removing the upper jaw. I have seen it done successfully, so called, time and again, but patients that I have been able to follow have all died within twelve or eighteen months. I admit that perhaps this is an average case for operation. The woman's pulse is 96 or 100; it is somewhat irregular, and as she is any thing but a robust subject I am very much inclined to the opinion expressed by Dr. Vance (and this has been my opinion from the first) that it is questionable, to say the least, whether this is an operable case.

Dr. Dugan: Do you not think that $33\frac{1}{3}$ per cent is very high? I have operated in quite a number of such cases, and so far have not lost a case from the effect of operation.

Dr. Rodman: It is higher than I had supposed. There is certainly no more careful man in following up cases than Butlin, and I rely more upon statistics furnished by him than by any one else. It is questionable in my mind whether this operation should have a place in surgery.

Dr. Vance (Tumor of the Neck): This young man I saw for the first time yesterday. He gives the history that two years ago he received a blow from a base ball on the right side of his neck, and since that time there has gradually appeared this tumor, which I would like for the members to examine. The blow was sufficient to knock him down and render him entirely senseless for a short period. The tumor has gradually increased in size for the last twelve months, and he has had several spells of excessive dizziness, so that he had to sit down.

DISCUSSION.

Dr. Rodman: How long after the blow was it before the swelling was noticed?

Dr. Vance: About six months.

Dr. Dugan: I am able to detect a pulsation in this tumor, but do not get that characteristic pulsation that we would expect to find in aneurism, still it may be an aneurism with very thick walls which prevents this pathognomonic symptom. I am unable to detect any bruit,

but considering all the symptoms I am of the opinion that the tumor is not an aneurism, but a growth lying against the carotid artery, from which it gets the pulsation. I would certainly operate, and be ready to ligate in the event it was necessary.

Dr. Roberts: This certainly has many characteristics of an aneurism. Pulsation can be gotten in every position in which the neck is placed, and is just as distinct when the neck is placed in such position that the tumor gravitates from the artery. I certainly detected a bruit. I think an exploratory operation ought to be performed at once, and if an aneurism it should be removed.

Dr. E. R. Palmer: I have nothing to say concerning the case except that I could not detect any bruit.

Dr. Geo. W. Griffiths: I did not get any bruit. I think the sounds heard are transmitted from the underlying vessels. I believe that an operation is the only thing that will determine exactly what the trouble is. Possibly something more could be told by the aid of a stethoscope, but I do not believe that an accurate diagnosis can be made without cutting down upon the tumor with a knife.

Dr. Rodman: I think, like several others who have spoken, that it is very questionable, to say the least, whether this is an aneurism or not. In the first place, it did not come on, from the patient's statement, until six months after the injury. In the second place, while there is a movement of the tumor, it is up and down movement very largely, not expansile as in aneurism. It does not feel like an aneurism, yet I think I can detect a bruit. It is a very doubtful case to me. I should not be surprised to find it an aneurism, and should be less surprised to cut down on it and find it a lymphoma. It is in a favorite region for lymphoma.

Dr. Palmer: If it is an aneurism, what is it an aneurism of?

Dr. Cartledge: I think Dr. Griffiths has about hit the nail on the head in speaking of this case, that it is impossible to make an accurate diagnosis without an exploratory incision. I do not think it is an aneurism. First, because I fail to detect any bruit. You get a decided pulsation, but I believe this is owing to the close proximity of the tumor to the blood-vessels; in fact, it is situated immediately over the artery. In the next place, when this tumor is raised up the pulsation in it ceases in a most marked way. If you will insert the fingers around the tumor and elevate it, the pulsation ceases almost entirely. As to the matter of causation, it is very unusual for blows of this kind to produce aneurism. A blow sufficient to produce aneurism would produce

such a subcutaneous injury as to be very marked. A blow from a base ball bat which would have produced an aneurism of the external carotid artery in this situation would have broken the larynx. Traumatic aneurisms are usually the result of penetrating wounds, and not from plain contusions. I am of the opinion that this tumor is external to the blood-vessels (the external carotid), and that a careful dissection will prove it to be a lymphoma.

Dr. Vance: I have proposed operation to the patient, and shall do whatever I find necessary. I believe that it is aneurismal tumor.

Dr. Palmer (Chronic Cystitis; Subcutaneous Tumors): This gentleman came to me last summer with chronic cystitis, which under the ordinary local treatment became very much better, and he went home, complaining, however, that he had considerable pain about the neck of the bladder. He also complained of pain in other parts of the body (which I confess I did not pay perhaps quite as much attention to as I might), particularly in the legs. I simply thought it was one of those indefinite conditions of the lower extremities that we often have in stricture and other troubles about the neck of the bladder. I think during the summer he called my attention to a swelling on one of his thighs, but it did not attract my notice particularly. He went home, and after a few weeks came back with only a slight remnant of his old trouble, excepting pain about the neck of the bladder, but complained of pains in the legs, and called my attention to one or two enlargements where the pains were chiefly located, then after that to enlargements elsewhere on his extremities, which led finally to an examination of his entire body and to the discovery of perhaps twenty or thirty subcutaneous tumors. I then sent him out to the University Clinic, and my son, under Dr. Goodman's direction, collected some of his blood, and made probably a half dozen mounts and stains with a view of ascertaining if the trouble might not be leukemia. He would have come here to-night and brought the mounts for your inspection, but was detained on account of some class work; but from the stains he made with Hænie's fluid, which is the only test, I believe, that is positive, there are considerable evidences of leukemia. The question as to whether the trouble is myxedema, multiple lipoma, or leukemia is one that I want determined to-night. In other words, it is a case for diagnosis. He has come here willingly for examination, with the hope that some light may be thrown upon his case. I think it is one of the most inter-

esting cases that has ever been presented before this Society. There are now fully half a hundred of these tumors on his body, one of which he says has existed for five years.

DISCUSSION.

Dr. I. N. Bloom: I believe it is a case of multiple lipoma. I can certainly feel three lipomata, one on the arm, one in the inguinal region, and another on the thigh.

Dr. Rodman: I think it is a case of multiple lipomata, or more likely fibroma molluscum, which is more common. The history of the case shuts out sarcoma. The tumors are benign.

Dr. Bodine (visiting): I think it is clearly a case of multiple lipoma.

Dr. Roberts: I agree fully with what Dr. Bodine and several others have said, that the trouble is multiple lipoma.

Dr. Mathews: I am now treating a patient for rectal trouble who has on the body at least a hundred such tumors—multiple lipoma. I judge from the history and clinical aspect of the case that this is the same thing.

Dr. Dugan: Like Dr. Mathews I have a case which is being treated in the clinic at the college for multiple lipoma. The tumors are very movable, and not attached to the skin. I think Dr. Rodman is correct in this case when he states that the trouble is fibroma of the deeper layer of the skin, inasmuch as the growths seem to involve the deeper layers of the skin rather than the subcutaneous fat. The skin can not be made to glide over it as we would expect in the ordinary fatty tumor.

Dr. Jas. Chenoweth: I was struck by what Dr. Dugan said in regard to the deeper layers of the skin being involved instead of the subcutaneous portion. I believe it is a case of multiple fibroma.

Dr. Palmer: One question is why this patient should have so many neurotic symptoms, burning pains, flushings, etc. It seems to me (and I have made quite a careful examination of the case) that these tumors wrinkle the skin from their attachment or involvement of the deep layer, and they do not strike me at all as being lipomatous in nature. I had fully determined a day or two ago (the patient is very anxious, and wanted to consult various doctors) that I would remove the tumor on the right forearm and have it submitted to a microscopical examination to determine the exact character. These tumors are too hard and too gristly in feel to be simply fatty tumors. I will remove a specimen and report result of the microscopical examination at the next meeting.

Dr. Vance (Ovarian Cyst of Long Standing): I exhibit for your examination some specimens from a woman you have heard mentioned several times, who died at the age of seventy-eight years. She had been the subject of an abdominal tumor since she was seventeen years of age, and during that time she had been tapped *one hundred and seventy-four times*, according to the best history we can get, the first tapping being done at thirty-four years of age. Dr. J. Q. A. Stewart tapped her one hundred and ten times, and I have tapped her fourteen times. She was in Owensboro for several years, and while there was tapped by local physicians, as nearly as we can ascertain, about fifty times. I always considered the trouble an ovarian cyst, but she would never consent to a radical operation. Death occurred yesterday at two o'clock from exhaustion. Last night Dr. Frank did a *post-mortem*, and the specimens which I show you I think are very interesting. It proved to be a cyst, and I believe an ovarian cyst. The left kidney, I take it, was the subject of nephritis; the right kidney is very much reduced in size, by pressure, I suppose. The spleen and uterus are also very small, probably as a result of pressure. Another curious feature is the formation of a lot of bone plates along the anterior wall of the cyst, probably as a result of the numerous punctures. Aspiration was practiced three times a year, on an average, and the amount of fluid drawn off at each operation was about twelve gallons.

The essay was read by Dr. W. L. Rodman; subject, Cancer and its Etiology. [See p. 409.]

DISCUSSION.

Dr. Mathews: One point in Dr. Rodman's paper as to age. Five years ago, in making a report to the Kentucky State Medical Society on cancer of the rectum, I stated that my record-books show more cases of cancer in this locality in patients under forty-five years of age than over forty-five. After a lapse of five years I still have the same record as far as my patients go. I have under observation now a boy of sixteen years of age who has undoubtedly a malignant growth in his rectum. I have a young boy only six years of age who has a spongy mass in his rectum that I can scarcely diagnosticate as any thing else but a malignant growth. I have a young lady, twenty-two years of age, in this city who has an undoubted cancerous formation in the sigmoid flexure. Therefore I am forced to believe that as far as age is concerned, rather than favor the ideas suggested by Dr. Rodman, with my individual practice it certainly is on the other side.

I want to say a word as to the heredity of cancer. I do not believe any right-minded surgeon to-day believes that it is in the strictest sense hereditary. Yet when I think of these young subjects having cancer, it is very natural to consider the idea of heredity as a possible factor. I do not believe that, as a child is born with a predisposition to tuberculosis, it may also be born with a predisposition to cancer. In other words, I mean to say there may be something in the temperament or the blood circulation, if you please, one temperament *versus* another, as, for instance, the florid complexion is an index to the development of the disease. It may be that in the construction or distribution of the blood-vessels themselves, that when subjected to a local irritation this excitation of the nerve force and blood distribution ends more quickly in cancerous formation than one that has not this peculiarity. It is the same predisposition that we have, for instance, to hemorrhoids. We often hear it stated that hemorrhoids are hereditary. We know that this can not be unless there exists some disturbance in the local distribution of blood. Therefore I do not believe there is a hereditary tendency or disposition to cancer only in that way.

As regards treatment suggested by Dr. Rodman, I think it depends very much upon the location, first, of the cancer; second, the degree to which the cancer has advanced, whether or not caustic applications can or should be applied. For instance, you take a cancerous tumor upon the external portion of the body where there is no breaking of the surface at all; I do not believe Dr. Rodman would apply caustics under these circumstances, when the tumor could be so easily extirpated with the knife. Take the rectum, or you might say the uterus; the disease is not always located in the os or cervix; it is not always located in the lower part of the rectum, and if it does begin there, there is a condition of the submucous tissues that renders the application of caustic, in my opinion, more dangerous than the knife and more unfavorable results in the way of sepsis, etc. It is very evident to me that the knife is preferable in these cases. Although I give Dr. Rodman great credit for his views upon this subject, I do not believe they will hold good, and in the majority of cases at least I do not believe we can substitute the caustic treatment.

Dr. Cartledge: First, I was very much impressed with that part of the paper which advocated the fact that we should select cases of cancer more carefully than we do for operation. That we should cease to operate upon forlorn and hopeless cases. Certainly this is a very excel-

lent suggestion. I feel this more from the fact that I am satisfied I am guilty, and believe the most of us have operated upon hopeless cases of cancer which should have been let alone. In doing this we probably drive away many cases that would otherwise fall into the hands of surgeons and be relieved by operation. I think we thus bring surgery into disrepute. Of course the most natural inference on the part of the laity is that the surgeon is to be blamed because the patient dies; that we do not know our business; that we are not familiar with what we attempt; that we are not familiar with cancer, or that we are all wrong about the outlook of such cases. I think we should pay more attention to the extension of tissue infiltrations in cancerous disease, and should show more courage as regards refusing to operate upon inoperable cases. In this day of antiseptic surgery we can do so many things in an operative way without danger of infection that it is an inducement to us to operate on cases to give them a last chance, when with a further study and a conservative estimate our better judgment would teach us to abandon them at once as hopeless cases.

As regards the causation of cancer, I do not know any more about it, of course, than others who have spoken, and the gentleman quoted in the essay by Dr. Rodman. We do not know the cause of cancer. One of the most plausible theories that has been advanced is the one of infection by a specific micro-organism as the exciting cause. I would say, as has been remarked by Dr. Mathews, that I am a firm believer in the inheritance of a predisposition to cancer; certainly our every-day observation bears this out. It surely can not be a coincidence that we see member after member of a family die from cancer. If it is possible to inherit a predisposition to diseases of the lungs, a defective nutrition of bone, etc., it is just as possible to inherit a predisposition to diseases of the epithelial tissue.

I am an advocate of the knife as a means of curing cancer, with very limited exceptions. About the only exception I know is the side of the nose, along by the side of the cartilaginous structure of the nose. In this situation small epithelioma can probably be reached with caustic acid and treated with less suffering than by picking up an extensive flap and transplanting skin, or doing some plastic operation. I do not believe that we can gauge the extent of our operation with caustic as we can do with the knife, neither do I believe that a caustic has in itself the power to arrest the development of cancerous tissue.

Dr. Bodine (visiting): I simply want to refer to one point in the discussion of cancer, and that is heredity. I had an aunt and she had three

daughters. The first child, a daughter, died of cancer of the rectum. The second daughter died of cancer of the rectum. Soon after the death of the second daughter, the mother died of cancer of the rectum, making three deaths in the same family. With these facts before us it would seem that there must be something in the idea of heredity.

Dr. Bloom: I have the record of several families in which the occurrence of carcinoma was sufficiently frequent to at least suggest the possibility of heredity. One was in a family of a distant connection of mine, in which two sisters and the mother died of cancer. The two sisters died of cancer of the uterus; the mother died of cancer some twenty years ago; I do not know where it was situated.

In another family two brothers and the father died of cancer. One brother died of cancer of the bladder, one brother died of cancer at the sigmoid flexure, and the father died in Europe forty years ago, and the only information I have is that the diagnosis was cancer. Here are two families where three members of each died of cancer, and while it does not prove that it is hereditary, it suggests heredity or hereditary predisposition. I was very much surprised when the essayist stated that the consensus of opinion now was that it was micro-organismic in origin and that heredity played comparatively little part in it. He did not speak of the embryonic origin. In regard to the influence of food, he said that spiced and peppery foods were about the only things which seemed to have any influence in the causation of cancer; at the same time he stated that in India cancer was extremely rare, when as a matter of fact not only the English inhabitants but the natives of India subsist largely upon the very food-stuffs mentioned. We owe the curries entirely to these people.

Concerning cancer in the insane: I was at Lakeland during the summer; the physician in charge took me into the dead-room and showed me a bladder he had taken from a patient in an autopsy. It was undoubtedly cancerous. The patient was a male.

One point that called attention to the micro-organismic origin of cancer was probably the action of the micro-organism of erysipelas. That theory was brought out some eight years ago. I do not know whether it was the result of an accident or not, but I think it was probably the result of investigations concerning the antagonism of different micro-organisms and leucocytes. Just as the leucocyte can and does destroy numerous pathogenic germs, preventing their producing their results, so it was thought that the micro-organism of erysipelas might be sufficiently strong to overcome the micro-organism that may possibly

cause cancer. Within the last three or four weeks I have read reports of quite a number of cases giving results of the inoculation of the germ of erysipelas, and the experiments seem to have been carried on pretty thoroughly, giving even a number of cases where after inoculation the patients died of erysipelas. The number of these cases cured by such inoculation as reported is remarkable.

What struck me first of all, in Dr. Rodman's extremely good paper, was the statement as to the use of caustics in the cure of this disease. I have thought not once but a good many times that there was more in this so-called quack method than we have heretofore imagined. About ten years ago a very distinguished physician was called to see a lady with cancer of the breast, more or less painful, and stated as his opinion that the woman would not live six months. The case was one of undoubted cancer; the woman went to a quack, caustics were applied, and her recovery was complete. I saw her possibly five years ago when she had already had retinitis albuminuria with hemorrhage; she lived in spite of that fact four years with severe Bright's disease. There was never a sign of the return of the disease.

Mosetig von Moorhof, to whom the profession is indebted for the introduction of iodoform (a service to the profession which certainly ought never to be forgotten), has advocated treatment of cancer with a paste. Of course no one uses caustics in the cavities; its use is indicated in a wide range of special cases, as those on the surfaces of the body. He has recommended the use of strong lactic acid in a paste with silicic acid; his claim was that lactic acid had an especial attraction for cancer, that it would follow it up and had very little if any effect upon healthy tissue. I used it once on a case of lupus (hopeless case) without any appreciable effect, except that I noticed it had no effect on healthy tissue. I do believe that we ought to use more caustic applications, especially in small tumors or beginning epithelioma. I have treated a number of them on the face where I have used caustic potash, and I have never failed to cure where I saw the patient sufficiently early. In very many cases I think a trial should be given this method; there is less danger from shock, and the use of caustics is not so painful as we would think.

Dr. W. O. Roberts: There are many points in the most excellent paper read by Dr. Rodman that I would like to discuss, and am sorry that the time had expired before I was reached.

JAS. S. CHENOWETH, M. D., *Secretary.*

Reviews and Bibliography.

The Throat and Ear, and Their Diseases. With one hundred and twenty illustrations in color, and two hundred and thirty-five engravings, designed and executed by the author, LENNOX BROWNE, F.R.S.E., Senior Surgeon to the Central London Throat and Ear Hospital, etc. Fourth edition. 734 pp. Philadelphia: Lea Brothers & Co. 1893.

Since the death of the distinguished Morell Mackenzie, Lennox Browne would doubtless with great unanimity be allowed the leading place among ear and throat specialists. Of great learning, great ability, and vast experience, he has here given the ripe fruit of long and earnest labors.

This work is not to be classed with the mass of productions that are poured forth from the press, mostly compilations, with alterations here and there to emphasize them as advertisements of their authors. The subject is here exhaustively treated on lines of thorough acquaintance with the anatomy, the physiology, and physics of the organs involved, the pathology of the disease to which they are subject, with possibly the best course of treatment that in the present state of knowledge can be applied.

The author insists in the outset on a thorough acquaintance on the part of the student with the right methods of examining the nose and throat, as an indispensable preparation for a right understanding of their diseased conditions as taught by the lectures, and the several manipulations necessary to this purpose are fully and carefully set forth.

To the author we have awarded the credit of having added to a thorough understanding of the diseases with which he deals the choice of the best treatment afforded by the present state of knowledge.

But just here we would admit having used a superlative to which the positive is wanting, for sometimes his best treatment, in our opinion, has few claims to be considered good. Thus, in the treatment of tubercular ulceration of the pharynx, recommending the galvano-cautery, he says: "After-pain there is little, for, as I have pointed out, galvanic has antiseptic and healing properties not possessed by any other form of actual cautery." Not to mention the incongruities and the *non sequitur* to be found in the sentence, and the calling galvano-cautery actual cautery, we would like to have help to understand how an operation, so brief in its course, could prove exceptionally antiseptic. We would like further proof to enable us to believe that an affection that would yield equally well to lactic acid, to menthol and the galvano-cautery, would not yield equally well to whatever might set up a stronger vital reaction in the parts. Likewise, in the treatment of diphtheria the author could not well afford to be without methods of treatment as effectual and as positively recommended as the methods approved by others, and which he as strongly condemns. When

one meets in bright array and orderly succession the terms "most efficient," "success which has attended the homeopaths," etc., he would conclude that the profession was suffering with an *embarras du richesse*, and that the only danger was that one medicine might get in another's way, since the cure is "but one man's work." Possibly the "success of the homeopaths" explains much and proves to us that up to this time the showing in the total of cases of diphtheria might not have been greatly worse as regards mortality if such a thing as medicine had never been known; albeit, we have but performed a simple duty in seeking for a remedy for this so destructive and insidious disease.

Of the author's view of the treatment of membranous croup, which he regards as altogether distinct from diphtheria, we regret to feel compelled to express a similar opinion.

It is very pleasant to meet throughout the volume complimentary references to American authors. Indeed, in his introduction he makes distinct acknowledgment of the fact that from no other quarter have so many original observations and suggestions of real practical value been derived as from the members of the American Laryngological Association.

The work is one for Americans as well as Englishmen to be proud of.

D. T. S.

A Manual of Diseases of the Ear. By GEORGE P. FIELD, M. R. C. S., Aural Surgeon to St. Mary's Hospital and Lecturer on Aural Surgery and Dean of the Medical School. Fourth edition. Illustrated with colored plates and wood-cuts. 382 pp. Philadelphia: Lea Brothers & Co. 1893.

To those who desire a concise work on diseases of the ear, clear and practical, this manual commends itself in the highest degree. It is as far removed as well may be from the character of a compilation, every page giving evidence that the author writes from his own careful observation and thoughtful experience.

It is just such a work as is needed by every general practitioner to enable him to treat intelligently the large class of cases of ear disease that comes properly within his province. The illustrations are apt and well executed, while the make-up of the work is beyond criticism. D. T. S.

Introduction to the Catalogue of the Collection of Calculi of the Bladder; upward of One Thousand in Number (besides foreign bodies) Removed by Operation. By SIR HENRY THOMPSON, F. R. C. S., M. B., Lond., Surgeon Extraordinary to H. M. the King of the Belgians; Consulting Surgeon and Emeritus Professor of Clinical Surgery to University College Hospital, London; Member of the Societe de Chirurgie of Paris, etc.

The collection to the catalogue of which this work forms the introduction was in 1892 presented by the distinguished surgeon to the Hunterian Museum of the Royal College of Surgeons in London, where it is now deposited, together with copies of the catalogue and introduction. The introduction sets forth the lessons to be derived from the history of the various cases or classes of cases upon which the operations were done. D. T. S.

Pediatrics.

In Charge of Henry E. Tuley, M. D.

INTUBATION.—It has been often wondered at that intubation has been so little used abroad, when such excellent results have been reported by our American operators, and it was with considerable interest that the reviewer read an article by Bernard Pitts, M. A., M. C. (*Lancet*, No. 3656), upon the status of the operation abroad. His article is prefaced by "Intubation for laryngeal diphtheritic obstruction does not seem to make much progress in general favor in England;" and he then goes on to "point out some of the causes which have prevented intubation from having had a more extensive trial in this country," reciting some interesting cases from St. Thomas' Hospital and from the Hospital for Sick Children, Great Ormond Street.

He reports two series of cases—rather too few to gain a good idea of percentages, as it has frequently been the experience of operators that they would have a run of fatal cases, and then the opposite result. The first series resulted as follows: "The cases in which intubation alone was done were thirty-five in number, with ten recoveries, or twenty-nine per cent. If to these are added the eighteen cases in which tracheotomy had subsequently to be performed, there are fifty-three cases, with twelve recoveries, or a little over twenty-three per cent. During the same period one hundred and ten patients were treated by tracheotomy alone, with thirty-two recoveries, or rather more than twenty-nine per cent; or, adding eighteen cases which were first intubated, there were one hundred and twenty-eight tracheotomies with thirty-four recoveries, or twenty-six per cent." "In the second series there are eleven intubations, with three deaths, or over seventy-two per cent recovered. . . . If to these are added the eleven cases which were intubated in 1890, there is a total of twenty-two cases, with nine recoveries, or, notwithstanding the unfortunate commencement, over forty per cent recovered."

He reports quite a number of cases in which *post-mortem* examination showed ulcerations, some quite marked, of the trachea had occurred along the course of, or at the end of the tube. This, in the opinion of the reviewer, is due to faulty tubes, as it has not been the experience of American operators using the approved O'Dwyer tubes to find ulceration present. He quotes from an article of Dr. Dillon Brown in which he states that "all modified O'Dwyer tubes had radical defects, and that every real improvement in the shape of the tube had emanated from the inventor;" but he does not seem to attribute this unfortunate complication to faulty tubes.

He expresses himself as in favor of tracheotomy as a routine operation for the relief of obstructed breathing in diphtheria, but he believes that

equally good results can be obtained by intubation, and that the choice of the method is determined by (1) the nature of the case, cases of very malignant type, and in all cases where membrane is very extensive in the mouth, and where there is a suspicion of extension below the larynx, early tracheotomy is advisable. (2) The surrounding conditions. He does not advocate its use in private practice. (3) The age of the patient. He suggests its use under two years of age. (4) The previous experience of the surgeon. He does not lay enough stress, in the opinion of the reviewer, upon the importance of intubation being undertaken by an experienced operator. (5) The consent of the friends.

Prof. W. E. Casselberry, M. D., published in the Chicago Medical Examiner (lvii, 201, 1888), an article which he read before the Chicago Medical Society, September 3, 1888, entitled "A New Method of Feeding, in Case of Intubation of the Larynx, by position, head downwards, on an inclined plane." He claims that it was original with himself, and says: "Regarding exact position, the angle has varied in different cases, but from forty-five to ninety degrees seems necessary to obtain the best results. The child is held on its back in the arms of the nurse, the legs elevated, and the head left to hang over the arm. Then it may take the mouth of the feeding-bottle, suck through a tube or feed from a spoon."

This article is quoted from, as in the paper under review the author mentions the above method of feeding, but states, "It was, at the suggestion of Dr. W. Edmunds, in use at the Evilena Hospital in 1880." This would give the priority of suggesting this valuable aid in the treatment of intubated cases to Dr. Edmunds; but a careful search through the literature of the subject, by Dr. A. E. Gallant, of New York, as far back as 1826, has failed to find a mention of it other than that by Prof. Casselberry.

The article is an interesting one, for the chief reason that so little has been written of intubation in England, and it reviews the work of other surgeons in this line. Ashby and Wright, in their work on Diseases of Children, devote but little space to the description and indications for the operation, and say, "In the only instance in which we have performed intubation on a living child the result was disastrous. A portion of the membrane was pushed down before the tube, and the child instantly choked. It was only by immediate tracheotomy and the use of artificial respiration that breathing was restored."

BILATERAL EMPYEMA IN AN INFANT THIRTEEN WEEKS OLD.—Cassel (*Deutsche Medicin. Wochenschr.*, 1893, No. 32, p. 768,) has reported the case of an infant, thirteen weeks old, that for ten weeks had presented symptoms of broncho-pneumonia consequent upon an attack of influenza. The child was pale and emaciated, its respirations short, shallow, and accelerated to fifty-six in the minute; the pulse regular but frequent. Physical examination disclosed signs of an encapsulated pleurisy upon either side, which upon puncture was shown to be purulent in character. Neither

pneumonia cocci nor tubercular bacilli could be found in the pus, although streptococci were present. A few days later an incision was made on either side in the sixth interspace in the axillary line, and twenty-four ounces of pus were evacuated from the left pleural cavity and eleven ounces from the right. The child withstood the operation well, and was better for a short time, but the suppuration persisted, with hectic fever and loss of flesh. After the lapse of more than a month a small portion of the sixth and seventh ribs on either side was resected, but the child only survived ten days longer.

At the *post-mortem* examination the left pleural cavity was found obliterated, except in the area of the empyema, which communicated with a cavity as large as an apple in the lower lobe of the left lung. The remainder of the lobe contained many caseous masses. The right pleural cavity was also completely obliterated, while the lower lobe of the right lung contained a large cavity and the remainder of the lung numerous caseous masses. Tubercle bacilli were demonstrable in the contents of the cavities. The bronchial glands were enlarged, and a section displayed caseation.—*Medical News.*

SULPHATE OF QUININE IN HUMAN MILK.—(Dr. Oui, in *Bull. Med.*, January, 1893.) This author has made some interesting experiments to determine the amount of sulphate of quinine in the milk of nurses. He analyzed the urine and milk of women to whom he had previously administered a dose of seventy-five centigrams (eleven grains) of sulphate of quinine. In the former quinine was always found in large quantities, while the milk, though frequently showing traces, only once contained an estimable quantity, two to three milligrams (one thirtieth to one twentieth grain) to one hundred cubic centimeters of milk.

In a series of investigations he found that the increase of weight in children to whose mothers quinine had been given was normal, and concludes that quinine can always be administered to women during lactation with safety.—*New York Therapeutic Review.*

ACUTE PARENCHYMATOUS NEPHRITIS FOLLOWING VARICELLA—Cassel (*Deutsche Medicin. Wochenschr.*, 1893, No. 32, p. 769.) has reported the case of a girl, four years old, who had previously never suffered with any infectious disease, but who upon the sixth day of a febrile illness presented a typical varicellous eruption. The urine at this time contained no albumen, but nine days later, when she was brought on account of a swelling of the face and diminished renal secretion, the urine contained blood, albumen, and granular and epithelial tube-casts. In the following days the condition of affairs progressively improved, and so continued to do until the child was lost from view.—*Philadelphia Medical News.*

Abstracts and Selections.

ELECTRO-THERAPEUTICS AND SUGGESTION THERAPEUTICS.—Moebius has thrown a bomb into the camp of the German electro-therapeutists, in the shape of five theses in which he denies very broadly that electricity has any curative qualities *per se*. He claims that in eighty per cent of all cases in which its action seems beneficial this is due to its psychical, not its physical influence.

Eulenberg has undertaken to answer Moebius' objections. In regard to the first point, that it has not been proven that electricity has a curative action on organic paralysis, and that paralyses which improve under electricity would do so without it, Eulenberg points out that the recovery would be slower and not so complete, and asks whether the results obtained in paralyzed animals are due to suggestion.

Moebius' second and third theses are, that many functional troubles are relieved by electricity and also by suggestion; *ergo*, electricity acts by influencing the mind only.

Eulenberg points out that these troubles are also relieved by morphine, atropine, bromides, or arsenic, and asks whether these too act psychically, as well as massage and hydro-therapy.

The fifth thesis declares that the extreme variation in action of electricity, both galvanic and faradic, can only be explained by assuming that it acts by influencing the mind of the patient. Eulenberg points out that we are dealing with vital processes and not with dead material, and that we can not predict the action of such well-known drugs as morphine and chloral in all cases. While combating Moebius' heresy in regard to the action of electricity, Eulenberg admits that Moebius has done a good work in pointing out the uses and benefits of psycho-therapy, and calls attention to the facts that electricity as administered by the non-expert physician is liable to be the failure that Moebius has described, and that general knowledge of its therapeutic application has not kept pace with the distribution and improvement of the electric armamentarium.—*Boston Medical and Surgical Journal*.

TRIONAL AND TETRONAL AS HYPNOTICS AND SEDATIVES FOR THE INSANE.—Mabon's conclusions from a careful series of investigations with these drugs are as follows:

These new remedies both have a marked hypnotic and sedative action, but trional appears to be the more serviceable as a hypnotic for the insane. On the other hand, small doses of tetronal appear to give the best results as a sedative. As a rule, the hypnosis which is produced is calm and quieting, and resembles very closely natural sleep. In a few instances unpleasant

after-effects are noticed, but in no case do they continue long, nor are they at any time alarming. They do not depress the heart's action. In the majority of cases fifteen grains (one gram) of trional given in hot milk at bedtime will produce sleep of from six to nine hours' duration, which is not accompanied by dreams. The time it takes to produce this effect is, in favorable cases, from fifteen to forty-five minutes, although it may be prolonged to over two hours.

With tetronal it is found that generally fifteen grains (one gram) are required to obtain the same results, and as this drug is twice as expensive as trional the latter is to be preferred, as a rule.

Both of these drugs have the effect with some patients of producing sleep for two nights after a single administration. Their sedative action appears to be most satisfactory, and with few exceptions does not produce a drowsy or stupid condition.

The dose of trional as a hypnotic is from ten to thirty grains (grams .66 to 2), but it is advisable to begin with fifteen grains (one gram). As a sedative ten or fifteen grains (gram .66 to 1) at least are required, but in some patients even forty-five grains (three grams) will not produce any effect. The dose of tetronal is from five to thirty grains as a hypnotic, but in the majority of cases fifteen grains will be required to produce a satisfactory sleep. As a sedative five or ten grains (gram .33 to .66) given once or twice a day will generally prove to be of benefit.—*Boston Medical and Surgical Journal*.

THE RESTORATION OF HEARING TO THE DEAF.—By analogy with good results obtained in other forms of loss of functions from disuse, it seems reasonable to hope that in some cases of deaf-mutism it may be possible to restore some degree of hearing, as well as of speech, by means of acoustic exercises. The idea is not a new one, and was long ago acted on. Upon this line of thought Urbantschitsch (*Wiener klinische Wochenschrift*, 1893, No. 29, p. 525) has made observations upon a number of deaf-mutes who by methodic exercise not only regained the faculty of hearing vowel-sounds, but also acquired the ability to hear and to repeat whole sentences. Some of the cases, upon first examination, appeared totally deaf, hearing neither through the air nor through the bones of the skull. The restoration of hearing to an apparently totally deaf person obviously implies that there can not have been actual deafness, but only an inability to properly interpret acoustic impressions. A development of the auditory sense was equally a result of the exercises, sounds that were previously not at all heard being readily recognized and differentiated. The exercises consisted in indicating by sign or symbol the sound to be made or the letter to be spoken. As at times they proved quite fatiguing, they were at first given for half an hour, daily, subsequently for an hour, preferably without the use of a speaking-trumpet.—*Medical News*.

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"*NEC TENUI PENNÂ.*"

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MECHANICAL VIOLENCE IN THE TREATMENT OF DIPHTHERIA.

The Boston Medical and Surgical Journal, of November 16th, calls attention to the returning swing of the therapeutic pendulum, which seems to have gone too far surgery-ward in the treatment of diphtheria. The physician whose cases have been taken out of his hands by the specialists will doubtless contemplate the change with satisfaction; but, if the following represents the latest teachings upon the subject, the pendulum is going to swing too far medicine-ward. The editor says:

At this time of renewed and enthusiastic study as to the nature of the infection of diphtheria when diagnosis is aided by cultures taken directly from the patient's throat, and when the treatment is so apt to be made too purely local, it is well to consider the effect of mechanical violence upon the throat.

Dr. J. R. Culkin (New York Medical Record, October 14th), of Rochester, calls attention to this subject in a recent article, in a spirit of fairness and common sense. After speaking of the various types of the disease, and the course of systemic infection, he says:

The majority of the profession believe that diphtheria is a germ disease, and that the Klebs-Löffler bacillus is probably the cause of it. The experiments carried on by various bacteriologists confirm this belief, but they are not as yet numerous enough to enable us to say that it is so beyond doubt.

In considering the local effects of mechanical violence to the throat, we will do well to have in mind the following facts:

1. That we probably have in the throat pathogenic germs ready to invade every area laid bare of epithelium.
2. The poisonous ptomaines are more readily absorbed by a raw and bleeding surface than by one covered by epithelium.
3. That a portion of the involved tissue is already necrotic, another portion is nearly so, and the area surrounding those portions is acutely inflamed.
4. That it is impossible to render by any means known to us a diphtheritic throat antiseptic.

The numerous crannies and folds in the mucous membrane of a swollen and diseased throat defy the searching of a swab which, though saturated with antiseptic or caustic solution, soon becomes covered with mucus or bits of the necrotic membrane.

The advantage gained in most cases is more than balanced by the fatigue to the child, the irritation and unavoidable mechanical violence to the throat which opens out a new bleeding point for fresh absorption of ptomaines, a new entrance of bacilli. The injuries resulting from compression of the tensely swollen glands about the jaw in severe cases, when the mouth is held forcibly open, are not to be disregarded. Empty lymph channels absorb poison and convey it more rapidly than full ones, and vomiting makes empty channels.

Important as are the cleansing and disinfecting of the throat, the rational side of the question is often overshadowed by the desire to destroy a bit of membrane and a few germs. It should be always remembered that the condition of the patient with diphtheria is one of acute septicemia, in which the maintenance of strength, absolute quiet and nourishment, is of prime importance. Our first object should be to save the child, not to kill the germs.

If the "condition of the patient in diphtheria" were always, in all stages of the disease, "one of acute septicemia," the above would be good science and good sense; but in truth diphtheria is at the time of the appearance of the exudate upon the tonsils or fauces a purely local affection which may be successfully treated and further trouble aborted by local means. That the septicemia is a secondary condition is well proved by clinical experience, and the doctor who addresses himself simply to the general system, leaving the local trouble to take care of itself, will kill many a child by negligence whose life might have been saved by proper local treatment. Of course a wise therapist will deprecate the use of violent mechanical or chemical means, such as the application or insinuation of powerful caustics and the tearing off of pieces of membrane. But the most doubting non-surgical Thomas in the guild will become a convert to local treatment if he will himself apply, or have a competent nurse to apply, every three hours, to the

diphtheritic exudate, when accessible, the following prescription of J. Lewis Smith:

R. Acidi carbolici, gttss. x :
 Liq. ferri subsulphatis, }
 Glycerin., } āā f. 3 ij.

M. Sig: Apply every three hours by means of a camel's hair pencil.

Under this application no mechanical or chemical violence is done the throat. The membrane dries up, the germs are killed, and secondary sepsis in the majority of cases is forestalled.

Notes and Queries.

HYPNOTISM.—Hypnotism and suggestion have at different times claimed the attention of experimenters, but have not until recently been considered therapeutic agents. Animal magnetism of Mesmer, Hypnotism of Braid, and Suggestion of Charcot, is a brief history of the development of this strange phenomenon. Each of these experimenters has done much to unravel the mysteries surrounding this agent, but to Charcot must be credited the honor of snatching it from chicanery and giving it a certain respectability. Liebault, Liègois, and Bernheim must be commended for their zeal and interest, while Luys has plainly carried it beyond the limit of science and truth. Time will not permit to enter into a discussion of the various stages, the different methods, or into the points of difference between the Charcot and Nancy schools, but merely to indicate its applicability and the results that may be expected. I need not recall to you the wonderful results obtained by observers, the world over, during the years 1886-1890: how long-standing chronic diseases of the brain and cord disappeared like the dew, and how in it was found the panacea of human ills. These much desired qualities were, however, of very short duration, for the crucial tests were soon applied, and hypnotism and suggestion quickly found their proper sphere.

Hypnotic suggestibility depends first upon the presence of extreme instability of the cellular nervous elements, and secondly, upon a weak power of inhibition or control of the activity of these elements. Persons of a low order of intellect are not favorable subjects for hypnosis; neither are persons of a strong individuality, nor the insane. The class of cases most favorable for hypnotic treatment are the hysterical; first, because they can be easily hypnotized, and secondly, because the disease requires a treat-

ment which appeals directly to the perverted action of the cerebral centers. It surely is not indicated for exhibition purposes, or for the treatment of any nervous disease or state, unless all other remedies have been exhausted. Even in hysteria this holds equally true. Binswanger, of Jena, in reviewing the literature on the use of hypnotism in the treatment of the insane, finds that the best results were obtained in hysterical insanity, but in a number of cases of melancholia and chronic alcoholism hypnotic suggestion had marked success. Berillon, in treating three hundred cases, one third of which were hysterical, had good results in almost all from the use of hypnotism. Collins, of New York, Dujardin-Beaumetz, of Paris, and many others have had good results in hysterical conditions, and uphold the Charcot doctrine. Almost every functional nervous disorder and many of the organic diseases of the nervous system have been benefited by hypnotism. My cases were all of hysteria, and generally of the dull phlegmatic temperament. Neurasthenia and the excited states are rarely ever benefited. I agree with Berillon that hypnotism is indicated (1) in the spasmodic attacks of grave hysteria and the paralysis following, (2) in mono-symptomatic hysteria, (3) in ordinary hysteria, and in (4) hysterical insanity.—*William C. Krauss, in Buffalo Medical and Surgical Journal.*

ELECTRICITY ARISING FROM GAS AND WATER-PIPES.—A writer in *Electricite* has made the observation that there is a difference of potential between the water and gas-pipes in all houses, and that if one terminal of a telephone is joined to the water-pipe a crackling sound is heard in the telephone on lightly touching the gas-pipe, which of course indicates the passage of a current. By substituting a galvanometer for the telephone it is found that the negative pole is formed by the gas-pipe, the galvanometer deflection being permanent and constant in amount during several months, though there is a slight diurnal variation. These experiments have led to the suggestion that the pipes must be fairly well insulated from one another and might really act as conductors for telephonic communication. As a matter of fact, it is stated that conversation was successfully carried on without any other conductor between two houses at a distance of 100 meters apart, the microphone used in the experiment being joined to three bichromate cells. The small though distinct currents that are set up when the gas and water-pipes are connected are attributed to a slow chemical change in the pipes, which may thus represent the plates of a battery. This hypothesis leads one to think of the probable nature of these changes, and to wonder whether any effect is produced in the water contained in the water-pipes, or whether, perchance, minute traces of metal as a result of the change would find their way in solution into the water. If the latter event took place, another and hitherto unsuspected source of lead poisoning might possibly be traced.—*London Lancet.*

THE DOCTOR AND THE COOK.—The subject of food and its proper application is now assuming imposing importance. Familiar with the physio-

logical processes of tissue building and waste, the whole subject of nutrition is opened up for study. This brings into play chemical as well as physiological wisdom—that is, knowledge applied. But to obtain the desired ends it is not sufficient to know only the general character of the required foods. The physician must know not only what food-stuffs will answer the requirements, but he must know how such food-stuffs are to be prepared to work efficiently. This carries with it some knowledge of the kitchen for the simple reason that cooking involves processes of chemical change which may make or destroy entirely the value of the food-stuffs.

In sooth, the physician is expected to know all of some things and some of all things. The physician knows it is not sufficient to give the very vaguest instructions as to what a patient may or may not eat, and trust to the ordinary kitchen mechanic to produce the desired results. He must, if necessary, be able to give for the preparation of food directions as specific as he gives the pharmacist for the preparation of medicine. This does not necessarily mean that every physician must qualify as a *chef*. It will be sufficient for practical purposes, if every physician will study the food-stuffs in common use in the locality in which his work lies, and learn so that he can teach the modes of preparation by which the nutritive values of the various food-stuffs may be developed. The physician in the kitchen is no longer a joke.—*Medical and Surgical Reporter*.

Special Notices.

"COCA" has maintained its reputation as a powerful nerve stimulant, being used with good results in nervous debility, opium and alcohol habits, etc. The highly variable character of the commercial drug makes it uncertain however. ROBINSON'S WINE COCA (see page —) we believe to be a uniformly active article, it being prepared from assayed leaves, the percentage of Cocaine being always determined by careful assay.

DYSPEPSIA, WITH NERVOUS DEBILITY.—Invaluable:

R Fluid Hydrastis, 1 oz.;
 Celerina (Rio), 2 oz.
 M. Sig: Teaspoonful before each meal.

THYROID GLANDS.—Owing to the interest that has lately been shown in the use of Thyroid Glands in the treatment of myxedema, etc., and to afford physicians an opportunity of determining the value of this agent, Messrs. Armour & Co., of Chicago, offer to supply GRATIS a small quantity of "desiccated thyroid glands" to members of the profession, on application. The facilities of this firm for preparing the article are certainly unequaled, and the opportunity seems to us one which is worthy of attention, and which should be taken advantage of in the interests of medical science.

FOR INTESTINAL TENESMUS (COLIC).—

R Tr. opii camph., ʒi.
 Dioiviburnia, ʒij.
 M. Sig: Tablespoonful as required.

THE AMERICAN PRACTITIONER AND NEWS

"*NEC TENUI PENNĀ.*"

VOL. XVI.

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NO. 12.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

SOME AFFECTIONS OF THE EXTERNAL AUDITORY CANAL.*

BY S. G. DABNEY, M. D.

Professor of Physiology and Hygiene in Hospital College of Medicine.

When I reflect upon the subjects which usually engage the attention of this Society, I almost feel that an apology is due for occupying your time with a theme seemingly so unimportant as diseases of the external auditory canal. Yet I hope in this brief paper to present a few points of interest, and not entirely devoid of practical benefit.

The most common affection of this part of the ear is accumulation and impaction of the ear wax. Frequent as this symptom is, we are yet often unable to attribute it to any definite cause. It may be due either to overactivity of the ceruminous glands or to a dermatitis of the canal which prevents the passing outward of the wax as usually occurs. Barnett has observed that persons whose sweat glands are very active are likely to be annoyed by impacted cerumen, and it has been my observation that these cases occur more often in warm than in cold seasons. Whether this is due to overformation of wax or to its being softened and running down on the drum membrane is open to question, but the resemblance in structure between the sweat and the ceruminous glands gives color to Barnett's suggestion that their activity may be excited by the same cause. An accumulation of wax is more often produced by overzealous efforts at cleanliness than by neglect. The habit of pushing into the ear a little of the twisted end of a towel, or the use of instruments of any kind in the patient's hands, is much more

* Read before the Medico-Chirurgical Society, October 13, 1893. For discussion see p. 461.

likely to push any wax that is present farther in than to remove it. The symptoms of impacted wax are so familiar as not to require mention. They are most often of sudden occurrence, and very frequently are first observed after a bath, by which the wax has been so carried down as to press on the drum membrane. In such cases patients are in the habit of saying that they have gotten water in the ear and could not get it out. It will be observed that the symptoms produced by impacted wax depend largely on its position. So long as it is loose in the canal a considerable quantity may remain unperceived, but when pressure is made on the membrana tympani symptoms are often very annoying, and may indeed be serious. I recall the case of a young man who came to me in much anxiety because he thought his ears had been affected by a stroke of lightning. While out in a thunder-storm, and just after a clap of thunder, he felt that he suddenly became deaf in one ear, was dizzy, and a little uncertain in his gait. Examination revealed, resting against the drum membrane, a mass of wax, the removal of which gave entire relief to all the symptoms. No doubt, startled by the thunder, he made a sudden motion which jolted the wax down on the drum.

In a certain proportion of cases the condition of the ceruminous glands seems indicative of disease of the tympanum. This is best marked in the so-called proliferous or in advanced catarrhal inflammation. In such cases there seems to be atrophy of the sweat glands, and patients often volunteer the statement that their ears are dry and secrete no wax. In early catarrhal disease either of naso-pharynx or middle ear there is said to be an overproduction of cerumen. Thus it behooves us in every case of wax in the ears to search diligently for the cause, and especially to examine the condition of the middle ear and naso-pharynx. Yet in my own experience most cases are without any discoverable cause.

Methods of removing wax need little description. In the great majority of cases the syringe and warm water, properly used, are amply sufficient. When there is desquamative inflammation of the canal, the syringe often fails, and I find most satisfaction in the use of Buck's curettes, delicate forceps, and occasionally a small hook. But instruments are seldom needed, and should be used only by one accustomed to aural practice.

A few weeks ago a gentleman from one of the interior towns of this State consulted me in regard to slight deafness, accompanied by dizzi-

ness, disturbance of gait, confusion of ideas, and he said impaired memory. These symptoms had developed gradually, and were of some weeks' duration. Examination revealed in the left ear a mass whose central portion was wax, but whose chief bulk was made up of dried skin, the result of a desquamative inflammation of the canal. Syringing was found insufficient for the removal of this, and I gradually and laboriously picked it out with curette and forceps, softening it a little with a solution of bicarbonate of soda. After its removal the patient expressed himself as relieved almost entirely of all unpleasant symptoms. He was to depart that day for Detroit, and as his canal was still inflamed and likely to need attention I gave him a note to Dr. Eugene Smith, of that city. I have not heard from him since.

When the wax has been removed we often find the canal slightly inflamed, with a tendency to desquamation. In such cases yellow oxide of mercury ointment (gr. i to vaseline 3 i) is an old-established and valuable remedy. When there is much scaliness and itching, oil of cade (3 i to vaseline or olive oil 3 vi) may be used with advantage.

Diffuse inflammation of the auditory canal varies widely in its symptoms and its causation. Leaving out of view those cases which occur as complications of middle ear disease, we find irritation from picking at the ear with hair-pins, ear-spoons, etc., among the most frequent causes. The inflammation may be gouty. It is often eczematous. It is rarely diphtheritic.

Borsa states that the symptoms in the order of their occurrence are itching, pain, and a sense of fullness and heat. To these I would add in many cases pain in the movements of the lower jaw. Objectively we find deafness, redness, swelling, and later often suppuration.

The most variable of all symptoms is pain. Its degree depends chiefly on whether the inflammation is in the cartilaginous portion of the canal only, or involves the bony also. In the latter case it takes the character of a periostitis, and is often most intense. Indeed, even the agony of acute suppuration of the middle ear is not greater in severity and is more easily controlled than that of severe inflammation in deeper parts of the auditory canal.

The most intense cases of this character which I have seen have been in ladies whose general health was debilitated. Yet I call to mind also the case of a young man from Woodford County who was brought to me almost exhausted from the pain and morphia which he had been compelled to use for its control. He was sent to the Norton

Infirmity, and poulticing kept up constantly for five or six days. At the end of a week, by this and other measures of treatment to be presently described, he was discharged, well. Next to pain, the deafness and itching give most annoyance. The former depends on the obstruction, and varies with the degree of swelling; the latter (itching) is usually the first symptom, and the rough means used to relieve it by the patient often greatly intensifies the inflammation. Occasionally there is a mastoid periostitis complicating disease of the canal. It is manifested by the usual symptoms, but need not give the same anxiety as when it attends disease of the middle ear, as the inflammation is almost always confined to the periosteum.

In the treatment of this disease we of course look first for any constitutional cause, such as gout, syphilis, etc. As regards local treatment, there are two points as to which experience seems to differ greatly. They are the use of poultices and the value of early incisions. It is contended by many eminent aurists that continued poulticing gives rise to granulation tissue, and does more harm than good. Thus, Roosa says, "a poultice should never be applied to or on the ear for more than a few hours. They are almost as dangerous a remedy in aural as in ophthalmic practice," etc. I have not found this the case except when used after an incision or the opening spontaneously of an abscess. For the relief of pain and to subdue swelling there is, in my experience, no substitute for the poultice, but when there is free discharge it should be discontinued.

Next to poulticing in value is hot water allowed to run into the ear from a fountain syringe. The piston syringe should not be used; its force is painful. It is often well to use the poultice and hot water alternately. A salve of cocaine, menthol, and carbolic acid I have found of some service in allaying the pain and itching. Of course, when there is free discharge, the first indication is the thorough removal of this. In such cases the application of nitrate of silver gives the best result. The solution should be from twenty to sixty grains to the ounce.

As regards incisions into the swollen tissue, I have found them useless except to evacuate pus. The circular shape of the auditory canal holds the cut surfaces constantly in contact, and prevents the relief that might elsewhere be obtained from the lessened tension. When the incision is to be made, a few drops of a four-per-cent solution of cocaine should be injected hypodermatically, the syringe being used through a good sized speculum. A curved bistoury is the best instrument for the

purpose, carried in over the point of greatest tension, and cutting outward. With the use of cocaine this little operation is almost painless; without it, intensely painful. In obstinate cases a blister on the mastoid is sometimes useful. Leeches, invaluable as they are in acute supuration of the middle ear, have but little control over inflammation in the auditory canal.

LOUISVILLE.

ON AMPUTATION AT THE HIP-JOINT.

BY G. P. HACHENBERG, M. D.

Since the late war a radical change has taken place in the operation of amputation at the hip-joint under certain conditions. In the wars of Napoleon I, Baron Larrey performed the operation six times, with a mortality of five cases. For many years many of his distinguished surgical successors met with no better success. From such unhappy results it was considered by many a criminal practice to perform this operation.

Under this state of discouragement I was called upon to perform the operation in 1861 on a lad, seventeen years of age, who had an extensive strumous necrosis of the femur. I had hesitated to operate for a year or more, but the patient's suffering was so great that it was about his daily cry that I should "cut his leg off." Finally I submitted the case to able medical counsel, and under their approval, more than my own, I performed the operation. Having but little confidence in any of the usual flap operations, and as life is jeopardized in the ratio of their nearness to the abdomen, I thought of a plan that seemed to me would act more favorably. The authorities on hand made the amputation at the upper thigh, 1 in 7 prove fatal; in the excision of the hip-joint, 1 in 15 proved fatal. Taking the three operations into consideration, that is, including amputation at the hip-joint, what can be more conclusive than that the flap tends greatly to a fatal shock and septicemia. With these facts before me, I submitted my patient to the double operation of (circular) amputation of the upper thigh, followed immediately by excision of the remaining femur out of the joint. To effect this expeditiously I had instruments constructed expressly for the case: as the "flexible knife," made out of a watch-spring, to cut the upper femur out of the periosteum, and a holder to transfix the bone while this part

of the operation was performed, etc. The operation was enforced with facility, and the following are the advantages we thought in favor of this method of amputating at the hip-joint over the usual methods:

1. It removes the wound from the body, and thereby lessens *a priori* the tendency to mortality.

2. It is performed with less loss of blood.

3. The shock is not likely to be so great.

4. The surface of the wound is less.

5. The flaps (if such they can be considered) are shorter and more massive, and therefore tend less to sloughing.

6. A sufficient stump may be secured for the adjustment of an artificial leg.

7. Owing to the remarkably close dissection that takes place by using the flexible knife in cutting the bone out of a hypertrophic periosteum, may we not retain the physiological function of that membrane so as, in course of time, even to give osseous or cartilaginous consistency to the stump?

Unfortunately we finally lost our patient through secondary hemorrhage.

The operation was performed in the presence of an able corps of surgeons and physicians, and reported in the Boston Medical and Surgical Journal, vol. lxvi, and referred to by the Surgeon-General in his Special Circular No. 7, On Amputation at the Hip-joint.

The object I have in referring to this case at this late day is to establish my priority in causing an important change in performing this formidable operation; and why in my "Medical Consultation Book," in the list of "Proper Names in Medicine," I affixed my name to the operation. The report of the case drew special attention in the surgical centers of Europe, and was performed with modifications in several hospitals, but from the reports usually given as original operations. After the operation was accepted in this country, credit of it was dealt out in details to every operator, particularly when the operation was performed with success. In the late war, in the U. S. Army, the operation was performed seven times with success, cases reported as "Re-amputation at the Hip-joint." Since the war, in civil practice, the operation in this and European countries has been repeatedly performed with success.

While in winter quarters, 1862-3, at Buckhannon, W. Va., I was summoned to the home of Sergeant Phillips of the First Virginia Infantry,

about twenty miles through a guerilla-infested country. Amputation at the hip-joint was the operation indicated. He was suffering from a gunshot wound; the ball passed through Scarpa's triangle, fracturing the left femur close below the trochanters. He had been wounded nine months before I saw him, and in the military hospital was considered a hopeless case. I found him very much reduced, with a thigh enormously distended and fistulated at several places. I concluded not to amputate, but made a bold and extensive dissection in hunt for the ball, which was the source of all the mischief. I found it partly imbedded in an ossified formation between the fractured ends of the bone. I broke two bullet forceps in the attempt to dislodge it, and was now left helpless without the necessary instruments to prosecute further the operation. At the same time the patient was alarmingly affected by the chloroform. At this critical moment I quickly placed my knee under his thigh, and with a quick, heavy blow on his knee caused a surgical fracture of the thigh at the weak point where the ball was lodged. I was now able to pick out the ball, which was in two parts, with all the necrosed spiculæ, with my fingers. Under the care of a local physician, who assisted me in the operation, the patient finally recovered, with a leg about four inches too short. He was for many years a pensioner, and I am not aware but he is still living.

This was the most formidable surgical operation in my experience. But when the Surgeon-General called for reports of surgical operations of the war for the Medical and Surgical History of the Rebellion, while accepting others that I reported, this one he would not accept, or it was overlooked.

AUSTIN, TEXAS.

WHAT THE GENERAL PRACTITIONER SHOULD KNOW ABOUT DISEASES OF THE EYE.*

BY FRANK TRESTER SMITH, A.M., M.D.

Professor of Diseases of the Eye, Chattanooga Medical College.

That there is a lack of knowledge in the profession regarding the elementary principles of ophthalmology will hardly be denied by any one who is at all familiar with the facts. Our crowded college courses and the feeling among students that they are not required in actual practice to know any thing of the eye, owing to the multiplication of

*Read before the Tennessee State Medical Society.

specialists, are largely responsible for this. Again, the subject is so extensive that it is difficult to decide where to leave off the study; and, instead of mastering a few general principles with the more important facts, too often the matter is skimmed over, and a superficial knowledge of much is obtained instead of a thorough acquaintance with what is most necessary. It will be the object of this paper to define the minimum amount of knowledge of this subject which one should have before entering upon the practice of medicine. If he understands these things well he will find it much better for his reputation, his pocket-book, and his patient; for if he makes a mistake elsewhere the kindly earth will cover it up, but here an error will be a walking advertisement to his want of skill or lack of knowledge.

In the first place, it is not to be expected that every doctor should become a specialist, or in any sense competent to deal with all eye affections, but he should know enough to know his ignorance. Secondly, it is not necessary for him to understand how to fit glasses, but he should know the main indications for the use of spectacles; for example, presbyopia, diminished vision, asthenopia, headache, functional nervous disorders. In the third place, he should not attempt to use the ophthalmoscope for several reasons: First, it will not pay. He will not realize enough out of the cases to pay the cost of a good instrument. Then there is the cost and time of learning. It would be cheaper for him to pay a fee out of his own pocket to a competent specialist. He could not keep in practice for this work. Most books on diseases of the eye have a chapter on the ophthalmoscope, which always seemed to me as worse than useless.

We can divide the cases under consideration into four classes: first, those with impaired vision; second, those complaining of pain referred to the eye; third, the inflammatory cases; fourth, the miscellaneous cases. Your patrons have a right to demand that you know something of these, and not depend entirely on the oculist. You will be compelled to give advice in all these cases, and you should know how to advise and when it is necessary to call in a specialist. You should know that every case of impaired vision and any clear cornea should have the benefit of an expert examination, provided that there is any perception of light. The doctor should be able to test for perception of light. He should know that where there is no perception of light, or where the cornea is opaque, that it is not worth while to subject your patron to any expense for an examination. He should know, where spectacles

are supposed to be required, that the oculist, and not the traveling charlatan nor the optician, is the proper person to whom these cases should be referred. He should be able to diagnose between glaucoma and cataract as a cause for the poor vision, and not advise the former to wait until it gets ripe, with the result that a specialist is consulted when it is too late to preserve any vision.

In our second class of cases, in which pain is the prominent symptom, glaucoma is at once suggested. With the diagnosis of this disease every practitioner should be familiar. It does not require any skill to diagnose increased tension (hardness) of the eyeball in a well-marked case, and the other points of the diagnosis should be well understood. Pain in the eye without inflammatory symptoms is more often glaucoma than neuralgia. In some cases of glaucoma the reflex symptoms have predominated so that cases have been treated for biliousness. You should know enough to prescribe myotics until an operation can be performed.

The general practitioner will be most often consulted in reference to our third class of cases, the inflammations. In all inflammations of the eye atropine is indicated, with the exception of the inflammations of the conjunctiva. Even here it will, as a rule, do no harm, so that in a case of doubt it would be best to use it, as the neglect of this agent may result disastrously; but the doctor should know that it is to be used with caution in all cases over forty years, and that it is positively contra-indicated in cases where there is any tendency to glaucoma. While many of the inflammations of the eye tend to spontaneous cure, and others would get well if treated on the above general principles, still it would be better to consult a specialist early, and carry out a line of treatment laid down by him, than to send him the case after all other resources are exhausted. The doctor should know the indications and the contra-indications of atropine and also of eserine. In some cases it is difficult to diagnose between glaucoma and serous iritis. If it were iritis and eserine or pilocarpine used to contract the pupil the case would be made worse. If it were glaucoma and atropine or other mydriatic used the result would be disastrous.

Under the fourth head are included all cases of functional nervous disorders, reflex and otherwise, which may be benefited by wearing glasses, or by some treatment, operative or otherwise, of the eyes. This includes cases of asthenopia, headache, chorea, epilepsy, and all obscure nervous troubles. It is sufficient for you to remember that

many of these cases have been relieved and some cured by treating their eyes. Injuries of the eyeball should, as a rule, be referred to a specialist at an early date, and especially if there is a suspicion of a foreign body, on account of the danger of sympathetic ophthalmia.

An endeavor has here been made to briefly outline the minimum knowledge of this branch which a general practitioner should have. More might be useful; for instance, the size and mobility of the pupil will often aid in diagnosing cerebral affections or general diseases. What has been given seems to be indispensable to any one who wants to practice medicine conscientiously.

CHATTANOOGA, TENN.

Reports of Societies.

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.*

Stated Meeting, October 13, 1893, Dr. T. L. McDermott, President, in the chair.

Dr. W. L. Rodman (Malignant Disease of Antrum: Operation): I have a specimen here which does not seem to be a bone, but it is, nevertheless, the remains of a malar bone, the seat of malignant disease. It was removed to-day from a patient fifty-two years of age, female, living in Indiana, who came here with a well-marked tumor of the antrum, which proved to be a malignant growth. The direction of this tumor was upward and outward instead of internally, the direction in which these tumors usually grow, making the malar bone very prominent. The operation was performed yesterday, and I was assisted by Drs. Dugan and Tuley. I cut immediately down upon the malar bone, and this is the remains of it. It does not feel like bone at all; feels more like fibrous tissue. After removing the end of the zygomatic process, which was also diseased, the antrum was exposed and we removed with the curette a large growth, sarcomatous in nature, I take it. The antrum was then thoroughly cauterized with zinc chloride. Hemorrhage was quite profuse, but easily controlled by tamponing with gauze. The patient stood the operation very well; I believe when she went on the table the pulse was 116, and at the close of the operation her pulse was 120. What is a little remarkable is the fact that this evening her pulse is only 68 and of good volume.

*Stenographically reported by C. C. Mapes.

I was led to do this operation rather than the more standard one of excision of the upper jaw, on account of the fact that I think recent investigations have shown rather clearly that the old operation of excision of the superior maxillary bone is perhaps not a justifiable operation. Butlin, in reviewing one hundred and eight operations removing the upper jaw, states that the immediate mortality is rather more than 30 per cent, that of this one hundred and eight cases only five passed the three-year limit, which can be looked upon as a cure. There is very little, I think, to promise patients after excision of the upper jaw, because nearly all of them return very speedily, and, in view of the great mortality, other operations should be done if possible. The tumors affecting the upper jaw are in a very large percentage of cases malignant. In a paper read two years ago before the State (Kentucky) Society, held at Louisville, I went over the subject pretty carefully and found that 76.3 per cent are malignant, the larger proportion of them being sarcomatous rather than carcinomatous, and 23.7 per cent benign. Of these rather more than 8 per cent are cystic, the balance fibromas, osteomas, and enchondromas.

In the case reported by me to-night the tumor has not been subjected to a microscopical examination, but from its macroscopic appearance there is very little doubt in my own mind as to its being sarcomatous in nature.

DISCUSSION.

Dr. S. G. Dabney: I would like to ask whether, in early stages of these growths within the antrum, the so-called Heryng test is used for illumination within the mouth. My own experience with it in diagnosing suppuration of the antrum has been favorable. I believe, if we will observe just beneath the eye, we will find in diseases of the antrum the affected side is rather darker than the other, even when there is no difference in transparency lower down in the cheek. My recollection is that this test was first used for differentiation of tumors of the antrum to detect the solid from cystic tumors. Is its use satisfactory in making the diagnosis of tumors in the antrum?

Dr. D. T. Smith: I would like to ask the justification of any operation at all in this situation. A suppurative condition, I judge, could be ascertained and differentiated from others, which would naturally require operation, or opening at all events. On the other hand, if operation is demanded, I should think complete excision of the jaw rather than partial excision would be preferable and promise more for the patient in way of permanent results.

Dr. Rodman: Answering Dr. Dabney's question, I have never seen the test used; it seems to me it would be a valuable means of diagnosis. It would possibly enable us to make a more accurate diagnosis in these cases, because it would show if the tumor had encroached upon the nares as these growths usually do.

The objection to complete excision of the upper jaw is that the primary mortality is more than 30 per cent, and if you can not promise very decided benefits from an operation that gives so high a mortality, then it occurs to me that the operation is not justifiable. I was led to give this woman the benefit of surgery particularly on account of the fact that she was suffering great pain from pressure. I believe, by the removal of the diseased bone and the thorough curettement of the antrum, the patient's life will be prolonged, and the mortality of an operation such as was done in this case I do not think is at all considerable.

Dr. W. C. Dugan (visiting): There is another feature in this case that struck me as being very peculiar, and that is there was no encroachment upon the nares. The patient was able to breathe through the affected side without trouble, and in discussing the case at the last meeting of the Surgical Society, where the patient was shown, this fact was mentioned. It struck me then that if there ever was a favorable case for operation this was one. We were very much surprised at the operation to-day to find that the growth had extended from the malar bone to the upper portion of the antrum, rather than from the antrum outwardly. I agree with Dr. Rodman that the patient was relieved of a great deal of pain. She was unable to open her mouth before the operation, and I am quite sure she will be able to do so now, for in my opinion the pain was largely due to the tumor being beneath the masseter muscle.

Dr. Rodman: In reporting the case I forgot to mention the fact that this patient was unable to open her mouth before the operation, but as the masseter muscle was cut I am certain she will be able to do so now and masticate her food.

Dr. Dugan: I am very much surprised at the high mortality of this operation. I have had several similar operations lately without any immediate fatality, but, like Dr. Smith, I am rather doubtful in my own mind as to whether this operation should not have been total excision, as I feel confident that we could have gotten all the growth out.

Dr. Rodman: The literature of the subject is rather conflicting. Gross states that he operated upon twelve of these cases, excising the

jaw as many times, without a single death, and makes the most extraordinary statement that the operation is free from danger. Yet Butlin, in a very careful review of one hundred and eight cases, states that the primary mortality is more than thirty per cent, and only five of them lived past the three year-limit, which is ordinarily regarded as the proper time to suppose that a cure has been effected. I would pay a great deal more attention to Butlin's statistics than those compiled by anybody else, as we know that his life-work has been devoted to malignant disease, and he has shown most extraordinary energy in following up his cases.

The essay was read by Dr. S. G. Dabney; subject, Some Affections of the External Auditory Canal. [See page 449.]

Dr. Dabney (remarks following paper): I desire to report one case recently met with in practice in connection with the paper. The patient was a gentleman about fifty years of age, who this summer had an attack of erysipelas affecting the auditory canal of the left ear. I did not see him in that disease, but did see him about four weeks after his recovery. I found the canal inflamed and swollen, and there was a slight discharge. I tried first nitrate of silver, and later all the well-known routine remedies. Although there was swelling, I did not believe there was any pus to be evacuated. I applied a blister behind the ear, as this sometimes produces a favorable result; also used Fowler's solution internally without effect. Finally I made an incision into the auditory canal, and without my advice the patient used hot applications for a while afterward. The result of hot applications following incision was growth of granulation tissue in the canal. The patient left the city shortly after this and I have not seen him since. I report the case simply to show the obstinacy of some of these affections of the auditory canal; they are not dangerous, yet as this case shows, they are sometimes exceedingly tedious.

DISCUSSION.

Dr. J. M. Ray: One point that impressed me concerning the obstruction of the canal from wax, is the habit some people have of having recurrent attacks of accumulations of wax in the ear. I have in mind a man from whose external auditory canal I have removed twice a year, for the last four years, enormous accumulations of wax. His hearing powers are perfectly normal, and careful examination reveals

no disease of the middle ear. Again, its proneness to occur in warm weather.

With reference to inflammations of the external auditory canal, the majority I see involve the outer part of the canal and are furuncular. I have seen several cases where incisions have given relief, and a few in which they seemed to give no relief whatever. I think Roosa teaches that incisions as a rule give very little relief to inflammations of the external auditory canal. One of the best means I have found to give relief is to allow the patient to lie down and pour hot water into the external canal, keeping it filled with hot water. I do not remember to have seen a case involving the mastoid periosteum as a result of external ear inflammation. There is no doubt but in furuncular inflammations of the canal there is some general systemic condition that underlies it.

I have had under observation during the present summer a young man who has had a most obstinate attack of recurring furuncular inflammation of the external auditory canal. I saw him in four or five attacks; he suffered great pain, and at last I advised him to take a vacation and go to the country. He went up in Illinois somewhere, remaining two or three weeks, and has not had any inflammation of the canal since his return. While he was under my treatment I gave him tonics, Fowler's solution, etc., which seemed to have no effect. His trip to the country, getting fresh air and country food, seemed to produce a change in his condition for the better, and since his return to the city he has had no return of the ear trouble.

Dr. T. L. McDermott: In the last week I remember reading a pamphlet setting forth the fact that poultices applied externally had very little effect upon internal inflammations of the ear. In this article the author advocated the pouring of hot water currents into the ear, which would in the majority of cases afford relief. It struck me as a very wise procedure, and Dr. Ray's remarks recall it.

I have under observation now a little boy three or four years of age, who has fever, and apparently at first suffered from some bowel trouble; pain quite severe, but could not be definitely located owing to his age. On the second night he complained of severe pain in the ear, lasting through the night. His head was kept in one position, and this symptom was so persistent as to suggest torticollis. This morning he still complained of pain located in the ear; temperature yesterday 103° F., this morning $102\frac{1}{2}^{\circ}$ F. He has had a typical clonic spasm from the history elicited from the family. I believe that this child has some

trouble in the middle ear not yet fully developed, which is causing the elevation of temperature. Since I have seen the case there has been no contraction of the muscles which we would expect to find² in torticollis, and no tenderness anywhere. There is no contraction or dilatation of the pupils; no cough; no sore throat; no diarrhea; and nothing indicating disease, except this obscure ear trouble.

Dr. J. A. Larrabee: I believe that the child is suffering from rheumatism, a disease frequently overlooked in childhood.

Dr. Ray: There may be some middle ear trouble, but mastoid tenderness may occur from the drawing effect upon the sterno-cleido-mastoid muscle.

Dr. McDermott: It is one of three things, external ear trouble, rheumatism, or developing cerebro-spinal meningitis; the symptoms are not localized.

Dr. Dabney: The discussion has taken rather wider turn than the character of the paper called for. There is no doubt that hot water allowed to run for a long time is one of the best methods of treating inflammations of the external auditory canal, because the hot water reaches the drum membrane, whereas poultices must be an inch more or less removed from it. I believe that the fountain syringe is the most valuable for this purpose. Parents and nurses are very apt to use the piston syringe, which is too forcible, and adds to the irritation already existing. As regards complication of the mastoid in inflammation of the canal, I have encountered this in two or three cases in children, but the inflammation was always confined to the periosteum over the mastoid process and did not involve the cells of the bone.

Dr. Ray (Two Cases of Foreign Body in the Ear): I will report two cases bearing somewhat upon the paper read by Dr. Dabney—cases of foreign body in the external ear. I recently had under observation two cases in which insects had gotten into the antrum of the ear and remained there for some time. One case is now under observation. The patient is a young lady, who, while riding on a street-car at night, suddenly felt something enter her ear. She went home and poured something in her ear that she thought would kill the insect, and the next day consulted a physician, who said there was nothing in the ear. For six weeks she had no trouble, then she began to have violent ear-ache. She suffered several nights before consulting me. Upon examination I found the canal blocked by something I was unable to make

out the nature of. She did not at first give me the history of the insect. She said it had been so long she had almost forgotten the occurrence. I then began to syringe the ear, and removed several pieces of black material, and upon further syringing and with a dull curette I picked out a headless insect as large as a bean. After I had syringed this all out, and examined again, I could still see something lying at the bottom of the canal close to the drum membrane. The canal was so tender and inflamed that I could do nothing further toward removal, so advised the use of hot water injections. The ear suppurated in a day or two, and she went through a case of suppuration of the middle ear. After that subsided I could still see something in the canal, and with a strong solution of cocaine, allowing the patient to lie on her side for some time until anesthesia was produced, I passed a dull curette behind the body and picked out the head of the insect as large as a shot and very hard, which had remained there through the suppuration and for six weeks previously.

No. 2. The other case, a gentleman stepping off the street-car one night felt something fly into his ear, and suddenly became so dizzy that he could with difficulty walk. He went home and poured oil in his ear to kill the insect. He remained very dizzy during the next day. The second day he consulted me, and upon examination I discovered an insect lying in the canal. It was removed by syringing, when the patient again became very dizzy and had to lie down for a few minutes. The insect had dropped down against the drum membrane. The peculiar feature in the case is the intense dizziness caused.

Dr. McDermott (Ophthalmia Neonatorum): A lady called at my office with a little child evidently suffering from ophthalmia neonatorum. As the case was not in my line I advised that she consult an oculist. She said another physician attended her during delivery and had been treating the child's eyes since. Of course what the nature of his treatment was, or how often he visited the child, I do not know. I sent her to Dr. Ray, and I want to ask the doctor one question in regard to the subject; whether under proper treatment immediately after birth the trouble in the majority of these cases could not be averted.

DISCUSSION.

Dr. Ray: The case referred to by Dr. McDermott belongs to an unfortunate class. The corneæ are perforated, one eye collapsed, the

other seriously affected, but may retain a little sight. Ordinarily cases of ophthalmia neonatorum come on about four days after birth and run a very rapid and often destructive course. I do not know that I can say very much about the case in question. The visiting physician evidently did not impress upon the mother the importance of the trouble, as she had not kept the eye free from pus.

At the meeting of the American Ophthalmological Society the past summer quite an extensive discussion was carried on with reference to the responsibility of the doctor in cases of ophthalmia neonatorum, and it was the consensus of opinion that cases were sometimes lost, and it did not make any difference who treated them or the method of treatment, the doctor should not be held accountable for an eye destroyed in ophthalmia neonatorum. There is one class of cases that I believe almost invariably go on to destruction, and that is in a premature child. I never saw a case of ophthalmia neonatorum in a child of seven or eight months but the eyes were seriously injured. I had a case of this nature during the summer. I saw the child three or four days after the eyes became involved, and at that time one cornea had become infiltrated, the other eye quickly became involved, and in a short time was also destroyed. The case referred to by Dr. McDermott was a seventh-month child.

I believe that such children are peculiarly prone to this affection and suffer more severely from the effects than those born at full term. It is probably due to the fact that the resisting powers are greater in a child fully matured than one prematurely born.

Dr. F. Wilson: What is the most successful plan of treatment?

Dr. Ray: Perfect cleanliness is the best treatment I know of. I think the best local application is nitrate of silver; this to be used by some one who knows exactly how to do it. If due care is exercised I believe that a ten to twenty or even forty grains to the ounce solution of nitrate of silver can be employed with benefit. I remember a case I had several years ago in which I used a forty-grain solution of nitrate of silver, stopping a purulent ophthalmia in one eye of a child, the other eye, being seriously affected at the time. By thoroughly cleansing the conjunctiva and applying nitrate of silver it ran a very mild course, and in less than a week the eye had perfectly recovered. The other eye in which the trouble had existed for a greater length of time, was two or three weeks recovering and with a superficial corneal abrasion. I believe the time is not far distant when all obstetricians will

recognize the importance of preventive measures in these cases. I am sure such methods as those of Credé will prevent many cases. The Louisville City Hospital has, during my service, always been unfortunate in having a number of such cases.

Dr. Larrabee: In treating ophthalmia neonatorum I do not think it is safe to intrust the cleansing of the eye to any one except the physician himself. I have had some nurses of large experience, and even then it is very risky the first twenty-four hours of the treatment to intrust them with the cleansing of the eye, giving the most minute directions. It is a very difficult thing to do I find. The eye shuts up like a mollusk, and the more pus there is the tighter it is closed. It will hold a teaspoonful of pus. The lids come out to a level with the superciliary ridge, remaining there swollen. I have had a nurse tell me there was nothing in the eye, when upon a careful personal examination a large quantity of pus has been found. Therefore, as has already been stated, I do not think it is safe for any physician to intrust this work to nurses, even trained nurses. I have used nitrate of silver by preference, getting it in just as soon as I could. I have more confidence in it than in any other agent outside of cleanliness.

Dr. Smith: If there is one thing that has puzzled me more than any thing else in medicine, it has been to make up my mind as to the proper treatment for ophthalmia neonatorum from reading books. They generally recommend nitrate of silver, but scarcely two of them agree as to the strength that should be used. Some insist that it should be very weak, others insist that very strong solutions are desirable. I am very doubtful in the average case whether nitrate of silver is required at all. I believe that Dr. Ray has solved the whole problem in saying that absolute cleanliness is the best treatment. The child's lids should be thoroughly cleaned every half hour with water about as salt as the normal tears, or at least every hour, all the pus being removed by gently pressing the under lid, and the lids never be permitted to stick together. I positively enjoin that somebody be up with the child night and day. Probably the most of us have suffered from ophthalmia at times, and know how painful a small particle of pus is under the lid. By gently pressing the lid and passing the finger over it this can almost always be removed. I have had such satisfactory results in the treatment of this affection, simply using salt water, keeping the eyes perfectly clean, that I feel like using nothing else. I have employed nitrate of silver in some cases, trying to follow the teaching of the latest books; then I

would read the work of another author advocating a different strength of the solution, until I have found there is such a great variation that I have about come to the conclusion that any treatment which admits of such variation would admit of being dispensed with altogether. As a rule I do not believe we visit these patients with sufficient frequency, leaving the treatment too much in the hands of the attendants. We should see them often, and insist that some one be present at all times to keep the eyes clean, and taking pains to see that our instructions are understood.

Dr. J. W. Irwin: My views are a good deal in accord with Dr. Smith's in regard to the treatment of ophthalmia neonatorum. I have seen a number of cases of this disease which come on one, two, three, or four days after birth, and I have never seen a child to lose an eye or have a perforation of the cornea. Furthermore, in no instance have I had to apply nitrate of silver solution in the treatment of these affections. Had they been of gonorrheal origin it is possible I would not have gotten off so well. Therefore I am inclined to the opinion, so far as my experience goes, that this disease, even in the majority of cases, is not of gonorrheal origin. The treatment in the cases I have seen was simple. I have had the eyes washed out clean with a weak solution of borax and water, and subsequently with one fourth grain of sulphate of zinc to the ounce of water instilled into the eye with a dropper-glass six or eight times a day. In a few instances, where the suppuration was very profuse and where it was very hard to control, I had the nurse to apply a solution of bichloride of mercury, one grain to one ounce of water, with a camel's hair pencil once a day only. Two or three applications of this solution sufficed to put an end to the disease. This I believe to be the best means of all for controlling these disorders. When I was a student I was taught that sixty grains to the ounce nitrate of silver solution would be required in these cases. I have read in books that it takes anywhere from five to fifty grains to make a solution sufficiently strong to be effective. I have never yet had to apply to the eyes of a young child nitrate of silver in any form.

Dr. Dabney: I would like to say something in regard to both cases reported by Dr. Ray, as they are both of extreme interest. Concerning foreign bodies in the ear, I wanted to include something about this in my paper, but did not do so. A mistake that is very often made in removing foreign bodies from the ear is to use instruments. Sir William Dalby goes so far as to say that injury is far more often done to the

ear by attempted removal of foreign bodies than by the foreign body itself. In almost every case the syringe alone is sufficient for the removal of foreign bodies from the ear, and forceps, spoon or other instruments are both needless and dangerous, except in expert hands. In one class of cases the syringe should not be used, namely, when the substance is one that swells when in contact with water—peas, beans, etc. I remember one case where a child was brought to me who had gotten a bean in the ear; it had been syringed several times, but the bean had slipped deep in the canal and was swollen from the use of water in attempts to remove it, and the canal itself was already inflamed and narrowed. In that case it was necessary to give chloroform before the bean could be gotten out. It was easily removed, and in a day or two the swelling passed away. Cases of this kind, however, are very exceptional. Another case was a child who had gotten a grain of corn in its ear; the family physician had made several attempts to remove it by injections of water, but had not succeeded. The grain had been in the canal for some time, and the water had caused it to swell so that it could not be removed except by taking it out in pieces. This is nearly always the case where the grain is not removed by the first injection of water.

As regards live insects in the ear, patients very often go to their doctor and say they have a little bug in their ear, as they can hear it. I remember one case where a small insect had gotten in the ear of a patient and was still alive when I saw it many hours afterward, and was fluttering; but usually the insect soon dies after it gets in the ear.

I was particularly interested in the discussion of ophthalmia neonatorum. Just before the Society was called to order I mentioned a case to Dr. Tuley, which I saw for the first time to-day, and found with a deep ulceration of the cornea. The child is now about two weeks old; the accoucheur dismissed both the mother and child six days ago, and I suppose the child was then doing well and the eyes improving. Since that time, however, the ophthalmia has not improved, and now the condition of one eye is critical.

As regards the treatment of ophthalmia neonatorum, there can be no question but absolute cleanliness is the key-note to the whole situation. This carried out with care is usually alone sufficient for a cure, but to hasten the cure there is nothing equal to nitrate of silver solution, and I am a little surprised that Dr. Smith should have found such diversity of opinion among writers as to the strength to be used. For

ordinary purposes a two-per-cent solution, ten grains to the ounce, should be applied. In a report from the Presbyterian Eye and Ear Hospital of Baltimore, sent out last June, Chisolm says the old plan of treatment in this disease still holds good; that is, a four-per-cent solution of boric acid used by the nurse for cleansing the eye as often as matter accumulates, and the daily application of nitrate of silver by the physician, usually ten grains to the ounce. This is the course of treatment I usually follow.

I was particularly interested in the point made by Dr. Ray in regard to suppuration of the cornea being so much more frequent in children who were born prematurely. This is in accord with the well-known fact that disease of the cornea is most severe in debilitated subjects; even in adults the corneal condition is often an index to the general health.

Dr. H. A. Cottell: The subjects under discussion are exceedingly interesting, not only to the specialist but to the general practitioner. Concerning the matter of foreign bodies in the ear, I believe every general practitioner should keep an ear speculum and mirror, and know enough about the anatomy of the ear to make an intelligent examination, not simply turn the patient around to the window, as so many of them do, and look into the ear without speculum or glass. He does not see to the bottom of the canal by that means, and many patients are allowed to go away with foreign bodies in the ear. I keep a set of ear specula, and many times I have removed foreign bodies from the ear. I had the honor of removing an insect from the ear of a distinguished surgeon the other day. He came into my office stating that he "knew he had a bug in his ear, that he could hear it buzz," asking me to get it out. I took the speculum and glass, secured an illumination, and detected a little brown object in the canal, which proved to be a very small insect (of the beetle order, I judge), and alive. It was very easily removed by means of a syringe and some warm water.

An accumulation of wax in the ear is practically a foreign body, and sometimes sets up considerable trouble of a reflex character. I would like to have the subject of reflexes due to irritation of the external ear brought up some time for discussion.

A word or two in regard to ophthalmia neonatorum. Of course all doctors see this disease, and although I have never had a severe case to develop in my practice, I have had one or two pretty severe ones brought to me. One, I remember, came from another city; the eyes

appeared to me to be doomed. I did not have the temerity to attempt to treat the case. I sent the patient to the infirmary, and asked Dr. Cheatham to see it. I remember he put the child in charge of a trained nurse, and was very specific in his directions to have the eyes cleansed with considerable frequency, and that he used a solution of nitrate of silver of different degrees of strength, beginning with the weaker and going up to the stronger. In a few days the child was well. That child would certainly have lost its eyes if it had gone on under the treatment employed by the family physician.

Concerning the question of using peroxide of hydrogen in the treatment of purulent conjunctivitis, this agent ought to be the ideal remedy for that trouble, and I think the reason it is not much used is that it is too irritating, owing to the acid it contains. When the Oakland Co.'s came out some time ago it was received with enthusiasm, because it was claimed that it was only slightly acid. I took a bottle of the Oakland Co.'s and made some experiments with it, and while it is very much less acidulous than the other preparations it still contains quite an excess of acid, and is bound to be irritating. If used in the eye it would have to be diluted to such a degree that it would not have any marked effect. If chemists can make a peroxide of hydrogen which shall be neutral, they will put in our hands a very valuable agent.

Dr. H. E. Tuley (visiting): During my term of service at the Sloane Maternity Hospital in New York there were two hundred and two births; the Credé method was observed in every case, two drops of two-per-cent solution of nitrate of silver being instilled into each eye immediately after birth, and there was not a single case of ophthalmia neonatorum during that time. This method is followed in every case after birth, and I do not think they have had a case of ophthalmia neonatorum there in a long time. I know they have had none in the last thousand births.

Dr. P. F. Barbour (visiting): While I was in the City Hospital here we adopted a method of preventing ophthalmia neonatorum which succeeded in every case. This method was to cleanse thoroughly the child's hands with boric acid solution. It seems to me that they should receive attention. One of the first actions on the part of a child is to rub its hands into its eyes. I believe, if the hands as well as the eyes are kept cleansed with some mild antiseptic, there will be much less of this trouble.

Dr. McDermott: In all the women we deliver in the course of many

years it is possible that we might not have a case of ophthalmia neonatorum, then again it might occur very frequently. Of course there are reasons why there should be more cases in hospital practice, owing to the class of patients presenting at such an institution for delivery. Gonorrheal infection is much more liable to be encountered there than in private practice. Our discussions of matters of this kind will bring them to the attention of other and younger physicians, and I believe good will result from greater care exercised in an endeavor by proper treatment to prevent trouble in this direction.

Dr. T. H. Stucky (Case of Paraldehyde Habit): I would like to report a case of paraldehyde habit. The latter part of April I was called to see a young woman, twenty-one years of age, who had previously been addicted to the use of morphine; she had been in Illinois attending the Keeley Institute, and had been relieved partially. I found her very restless and nervous, and prescribed valerian and asafetida, but she was unable to take it. I then ordered three ounces of elixir paraldehyde (Flexner); saw her the next day, when she seemed much better, and told her if she had any further trouble to let me know. I heard nothing more in regard to the case until, I think, the latter part of September, when her husband came to me and asked if his wife could not stop taking that stuff; that she had had the prescription doubled in May and filled ten times, which was sixty ounces; in June had it filled sixteen times, which was ninety-six ounces; in July filled twenty times, making one hundred and twenty ounces; in August filled twenty-three times, one hundred thirty-eight ounces; in September filled thirty times, one hundred and eighty ounces. I went to see the patient, and she stated that she drank the medicine from the bottle whenever she began to feel a little faint or nervous. I was surprised to learn that it still produced sleep, and gave her decided benefit apparently; but the most interesting feature was, that I could not see it affected the heart to any marked degree. It produced absolutely no alarming symptoms, and her appearance was similar to what we see in a person addicted to strong drink; she resembled an individual who had been on a protracted spree. The paraldehyde was withdrawn the first of October entirely; she was placed in bed and watched carefully by a competent nurse, and I gave her valerian and strychnine. She seems to suffer just as one who is recovering from delirium tremens.

This patient consumed an average of six ounces of paraldehyde a

day, or one hundred and eighty ounces during the month. I have never seen a report of a case of this character, and it struck me as being very unusual.

DISCUSSION.

Dr. McDermott: I had an experience of similar character at the Springs this summer. A man was suffering from alcoholism, and I prescribed paraldehyde in small doses. The effect was so pleasing that he consumed the whole vial, six ounces, in one day without any perceptibly bad effect. In another case, at Seelbach's Hotel, in ordinary doses, it produced violent heart symptoms with evidences of poisoning. Here are two cases in which the action of this drug was directly opposite. I remember prescribing paraldehyde to another patient who was suffering from alcoholism. The druggist, two weeks afterward, called my attention to the fact that this man was getting from four to six ounces of paraldehyde per day, and asked if it was my wish to have it continued. I, of course, instructed that he be sold no more, as I did not intend for it to be continued. That case was similar to the one reported by Dr. Stucky—the man was going about the Springs taking four to six ounces of paraldehyde a day instead of whisky.

Dr. Irwin: What was the character of the heart symptoms?

Dr. McDermott: Palpitation; respiration was also depressed. I understand that this patient died three or four months afterward in New Orleans, but I did not ascertain the cause of death.

Dr. Irwin: I was greatly interested in Dr. Stucky's report; it comes right within the sphere of my own observations perhaps more than any other. I have had some experience in treating persons suffering from insomnia in its various forms, and have prescribed paraldehyde a number of times. I recall one case where a patient had been taking paraldehyde for nine months every night. The dose has not been increased, one half to one ounce every night. When he first began the use of paraldehyde it had a stimulating effect, as though he had been taking alcohol; but this effect did not last long. He then began to suffer from suffusion of the eyes, with redness of the conjunctivæ, and dilatation of the pupils, which would last for one or two hours after getting up in the morning. Soon after going out into the open air the pupils become normal but the suffusion of the eyes continues. He suffers from a little redness or flushing of the face; at times he shows evidence of uncertainty of gait, and in walking across the floor he staggers. He does not plant his feet on the floor as a healthy man should ordinarily do.

There is no other change in his condition ; it has not affected the heart, nor does it to-day.

Another gentleman came under my observation who had spent a year or two abroad, and had been taking paraldehyde for insomnia. He used Flexner's preparation in doses of one half ounce at night, causing sleep of six to eight hours. At the time I saw him he was suffering from a feeling of constriction about the stomach, as though a band had been tied around him. He had not been using alcohol or any thing that would have put his stomach out of order, and he thought the paraldehyde might have been the cause of his trouble. I had the paraldehyde stopped, had the urine examined, and found a trace of albumen with hyaline casts, slightly granulated. This was the report of the chemist. After two weeks without paraldehyde the constriction had passed away, the trace of albumen had disappeared, and so did the casts in the urine. He sleeps now without paraldehyde, takes no medicine of any kind, and I believe in this case it was only imagination that he could not sleep.

I have several other cases who are using paraldehyde, but these are most striking. The largest dose I have had to prescribe in any case was one ounce of Flexner's Elixir. One gentleman is taking pure paraldehyde, and he thinks it is the greatest remedy in the world for insomnia. The only bad effects I have observed after the use of paraldehyde are that in one case it produced suffusion of the conjunctivæ, flushing of the face in the morning, dilatation of the pupils, and a slight conjunctivitis. In a few instances in acute diseases I have prescribed paraldehyde in large doses to cause sleep ; I have given as much as six ounces in one night to one patient. This caused an acceleration of the pulse from ninety or one hundred to one hundred and twenty, and the patient awaking from sleep rather weak and feverish. These are about the only untoward symptoms I have observed so far.

A FEVER ENUNCIATOR.—The Paris correspondent of the *Lancet* describes an electrical system, recently invented, to be used in a hospital ward in much the same way as an automatic fire-alarm system in a mill. Each patient is to have in his axilla an apparatus connected with an electric enunciator, which rings an alarm if the temperature rises above a certain point.

Reviews and Bibliography.

A Treatise on the Science and Practice of Midwifery. By W. S. PLAYFAIR, LL. D., F.R.C.P., Physician-Accoucheur to H. I. and R. H., the Duchess of Edinburgh; Professor of Obstetric Medicine in King's College, etc. Sixth American from the eighth English edition. With Notes and Additions by ROBERT P. HARRIS, A. M., M. D. With five plates and two hundred and seventeen illustrations. 697 pp. Philadelphia: Lea Brothers & Co. 1893.

This edition of Professor Playfair's popular work is fully entitled to be denominated "revised." The parts that have most felt the revision are those relating to extra-uterine pregnancy, cesarean section, symphyseotomy, and puerperal septicemia, as it is in these branches of the subject that most marked progress has been made in the last few years.

In the method of treating his theme, that is in clearness, in perspicuity, in a smooth-flowing and yet terse literary style, notwithstanding the great number of new claimants in the field, this work still stands without a superior. The style may be in some respects regarded as a reflex of the character of the work. He has followed rather than led thought; he has undertaken to cope with few of the profound difficulties and intricacies of the subject. He has in these matters seemed to follow rather than lead the great original thinkers, albeit with excellent discretion and judgment.

The chapter on embryology is commendably brief, and might even be made briefer still or relegated altogether to works on physiology. The doctor who has not learned embryology during his studies in physiology is not likely to master it as an introduction to his text-book on obstetrics.

As in former editions considerable attention is given to a consideration of the possible causes of periodicity in menstruation and to the causes of labor. As usual in speculative matters the author advances no theory of his own, but gives enough of the contradictory views of others to leave the questions virtually where he takes them up, himself concluding that we must admit ourselves to be still in entire ignorance of the reason why labor should come on at a fixed period.

His teachings on the treatment of the various forms of anomalous and difficult labors are clear, full, and explicit, and these, being practical matters, bear the full stamp of the author's high authority. Especially valuable is the note of the editor at the close of the chapter on occipito-posterior positions.

The author is not a great partisan of the cesarean section, and seems to hold that induction of premature labor, after once a craniotomy from faulty pelvis has been performed, ought to be as a rule resorted to. This is in fact what nature has been practically doing through the eons, only nature killed the mother as well as the child, and thus checked the increase of women with defective pelves.

Among savages, where nature is left to take its course, women with small and otherwise defective pelves are soon eliminated, and labor among them becomes a simple matter.

The author is mild on the question of curetting the uterus in puerperal septicemia, but is more strongly in favor of the use of perchloride injections into the uterus, claiming that Koch has proved it to be the only reliable one. For our own part we should be pleased to see some of the advocates of curetting engaged in the task of scraping off the interior of the uterus after it was slit open and laid on a table. We doubt not that the conclusion would be reached by the time the surface was made clean, that the vast majority of curettings had left much of the surface of the uterus untouched.

But perhaps we have said too much of a book so well known, and a book that already has the praise of the civilized world: D. T. S.

Human Anatomy: A Complete Systematic Treatise by Various Authors, including a Special Section on Surgical and Topographical Anatomy. Edited by HENRY MORRIS, M. A. and M. B., Lond. Illustrated by seven hundred and ninety-one wood-cuts, two hundred and fourteen of which are printed in colors from drawings made expressly for this work by special artists. 1286 pp. Price, \$7.50. Philadelphia: P. Blakiston, Son & Co. 1893.

The casual student of anatomy might have been led to think that in the contest between Quain and Gray in their successive editions for the palm of excellence there was little hope for an entirely new entry. The most casual glance at this new claimant for honors in the field of anatomy must dispel any such notion. Magnificent as are the works mentioned, there are features in this that must cause any one to hesitate before making a choice.

Besides containing all the improved methods of marking the plates to show the relations of parts, the origins and insertions of muscles, ligaments, and the like, in the letter-press, all the sub-headings are marked in bold type so as easily to fix the attention. The general style of description seems to be as accurate and expressive as language can well make it. Like other recent anatomies, the greatest improvement has been made in the description of the nervous system, that being the part presenting the greatest amount of recent progress.

The work is designed for the use of students, and aims at being a complete and systematic description of every part and organ of the body, so far as it is studied in the dissecting-room, the different sections having been written by separate authors who are known to have devoted special attention to the subjects allotted them. If we were to suggest an improvement, it would be the adoption of the plan of tabulating in groups the important organs of the body, so that they can receive special attention and be made the subject of special efforts at memorizing. Not one man in ten thousand can take up so large a subject, giving a uniform measure of study to each feature, and gain any thing like a thorough and ready acquaintance with it. The laws of memory require that certain leading parts shall be fixed in the

memory by frequent repetition, so that they can be employed as centers of association in the attainment of the knowledge of other parts. As first the alphabet is learned, as the multiplication table is made part of the furniture of the mind as a preparation for mathematics, so in anatomy should the names of the organs be grouped according to location, function, and the like, and committed ineffaceably to memory, if one would aim at a thorough and available knowledge of the subject.

The plates are of the finest order, the type is good, and in every way the book is a credit to authors and publishers.

D. T. S.

Hospitals and Asylums of the World ; Their Origin, History, Construction, Administration, Management, and Legislation, with Plans of the Chief Medical Institutions, accurately drawn to a Uniform Scale in addition to those of all the Hospitals of London in the Jubilee Year of Queen Victoria's Reign. By HENRY C. BURDETT. In four volumes and a portfolio. London: J. & A. Churchill. 1893.

The great work on hospitals and asylums of the world, upon which Mr. Henry C. Burdett has been engaged for more than a dozen years, has been at last completed, and has on all hands been hailed with a hearty welcome as a most valuable addition to standard medical literature. The work is a monument of patient research and compilation on the lines of well assimilated literary treatment. The "origin, history, construction, administration, management, and legislation" of the hospitals and asylums of the world is a large title, but it is justified by a superb work. The author goes back to the earliest ages, and shows how the idea of hospitals most probably first had its origin in the gathering of the sick about the temples, together with their exposure in the milder climates, in order that the public might suggest such treatment as the experience of each had approved.

So far from hospitals having been a modern provision, evidence is produced proving conclusively that during the vogue of the gentle teachings of Buddha in India in the three centuries before the Christian era that country was dotted over with hospitals. Among the hospitals given as approaching perfection, our own Johns Hopkins Hospital is accorded a place in the very front rank. The pages relating to asylums, or rather introducing the consideration of asylums, are of especial interest, showing the horrid mistreatment of the unfortunately insane and epileptic, growing out of the idle fancy set forth in the early teachings of the Christian era that these people were possessed of devils.

But space will not permit to refer to this superb work, even in its comprehensive headings, so extensive and exhaustive is its character. Such a work would, in the very fact of its production, do credit to the most liberal government; how much more to an individual publishing house and to a single author. It is one of those works which in the centuries to come will be held precious as a faithful mirror of the charities of its time, and a faithful history, of all that have a history, of former ages. It is a work that should be among the collections of books in every hospital and asylum, and in every public library.

D. T. S.

A Treatise on Ophthalmology, for the General Practitioner. By ADOLPH ALT, M. D. Second edition, revised and enlarged. With one hundred and forty illustrations. 330 pp. St. Louis: J. H. Chambers & Co. 1893.

In this, as in the former edition of his very excellent work, the author assures us that he has adhered to the original plan of making it a useful guide to the general practitioner who may be forced to take care of certain eye diseases. The work is not at all intended for the specialist.

Most works on ophthalmology intended for specialists are sealed books to the "general practitioner." The technical terms, especially those relating to optics and the various formulæ, require much study to understand, and much review to remember. In this work all such matters are practically eliminated, and the author gives us in a pleasant way, and a way that can be easily understood, nearly all the important or essential points in the treatment of the diseases to which the eye is subject.

The work is a credit both to the author and publisher, and while no general practitioner can make a mistake in adding this to the shelves of his library many a specialist may gain something in the way of familiarity with diseases of the eye from the vivid and vigorous descriptions the author employs.

D. T. S.

THE MEDICAL NEWS VISITING-LIST FOR 1894: Weekly (dated, for thirty patients); Monthly (undated, for one hundred and twenty patients per month); Perpetual (undated, for thirty patients weekly per year), and Perpetual (undated, for sixty patients weekly per year). The first three styles contain thirty-two pages of data and one hundred and seventy-six pages of blanks. The Sixty-Patient Perpetual consists of two hundred and fifty-six pages of blanks. Each style in one wallet-shaped book, pocket, pencil, rubber, and catheter scale, etc. Seal grain leather, \$1.25. Philadelphia: Lea Brothers & Co. 1893.

THE PRINCIPLES AND PRACTICE OF SURGERY, by John Ashhurst, jr., M.D., Barton Professor of Surgery and Clinical Surgery in the University of Pennsylvania; Surgeon to the Pennsylvania Hospital, Philadelphia. New (sixth) edition, enlarged and thoroughly revised. In one octavo volume of one thousand one hundred and sixty-one pages, with six hundred and fifty-six engravings and a colored plate. Cloth, \$6; leather, \$7. Philadelphia: Lea Brothers & Co. 1893.

A PRACTICAL TREATISE ON DISEASES OF THE SKIN, for the use of students and practitioners, by J. Nevins Hyde, A. M., M. D., Professor of Dermatology and Venereal Diseases in Rush Medical College, Chicago. New (third) edition. In one octavo volume of eight hundred and two pages, with nine plates, of which three are colored, and one hundred and eight engravings. Cloth, \$5; leather, \$6. Philadelphia: Lea Brothers & Co. 1893.

A TEXT-BOOK OF OPHTHALMOLOGY, by William F. Norris, M.D., Professor of Ophthalmology in the University of Pennsylvania, and Charles A.

Oliver, M. D., Surgeon to Wills Eye Hospital, Philadelphia. In one very handsome octavo volume of six hundred and forty-one pages, with three hundred and fifty-seven engravings and five colored plates. Cloth, \$5; leather, \$6. Philadelphia: Lea Brothers & Co. 1893.

Foreign Correspondence.

LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

A New Fever Hospital; The British College of Physical Education; Smoking and Cholera; The Opium Question; Preparation of Thyroid Juice; A Fresh Local Government Board Inquiry; Report of Committee as to the Disposal of the Dead; Sulphate of Cinchonidine; Strychnine in Cholera.

As a result of the notification of infectious diseases required by the recently passed Parliamentary acts it was discovered that London was suffering from the scourge of scarlet fever, which had up to that moment been almost unsuspected. The Metropolitan Asylum's Board soon found that they could not provide sufficient accommodation, and last year opened a temporary hospital. This gave them altogether 3,300 beds; it was then discovered that over 2,000 more were required. 33 acres were obtained at a cost of over £12,000; of this area 23 acres have been reserved for the purposes of a permanent hospital, shortly to be commenced, while the remaining 10 acres are being covered with temporary buildings for the purpose of a temporary hospital to contain just over 400 beds, a first installment toward supplying the deficiency of 2,000 beds. This is the only temporary hospital which it is proposed to erect this year, and it will cost approximately £60,000. The patients sent to it will be drawn mainly from the southwestern districts, and the disease treated is to be scarlet fever with occasional cases of typhoid and diphtheria. The cost of maintaining the buildings, apart from capital charges, repairs, etc., is expected to be about £10,000 a year. Accommodation is provided for the nurses in separate blocks, there being forty nurses and fifty assistant nurses. The charge nurses have each a separate bed-room, and the assistants each a cubicle. With few exceptions the buildings are constructed with walls and roofs of timber framing, covered externally with boarding, felt, and galvanized iron, the walls standing upon brick and concrete bases. The floors, in order to prevent loss of heat, are formed of wood laid upon felt and fir fillets, the whole resting upon cement concrete six inches thick. The whole of the internal wood-work has been varnished. There are 16 main ward pavilions, each receiving 24 beds; each

is 144 feet long, 26 feet wide, 11 feet high to the springing of the roof, and 13 feet 6 inches high to the ceiling, giving to each bed a wall space of 12 feet, a floor area of 156 feet, and a cubic capacity of 2,000 feet.

A circular signed by Dr. Thomas Savill, M. D., the Chairman of the British College of Physical Education, has been issued, appealing for aid to enable the council to carry out the objects of the college. It is submitted that a building is necessary where lectures on the science and theory of physical culture and practical instruction in gymnastics may be given. In order to accomplish this the sum of about £10,000 is necessary.

With regard to an outbreak of cholera at the Greenwich Workhouse it is said that it is very noticeable that male inmates who had been great smokers or who had been in the habit of chewing tobacco had passed unscathed through the epidemic. Nearly every adult male in the workhouse was or had been a smoker, and the statistics of the epidemic show that only eighty-three males had been attacked as compared with one hundred and sixty females. Generally speaking, the male attacks were of a mild nature. There were several old Irish women in the workhouse who smoked before their admission (and now when they could manage it), and it is stated that not one of them had been attacked. The investigation which has been held leads Dr. Burney, the Senior Medical Officer of the Institution, to believe that the epidemic must have been caused by the water. The children who drank but little of it had not been attacked. The *post-mortem* examination has revealed the presence of comma bacilli in the intestines, and when the analysis of the water is complete it will be seen whether or not the bacilli had been conveyed by that means into the system.

The opium question in India is still open. Some say the drug is a curse to the country, others a boon which could not be done without. Sir I. Strachey gave evidence lately in which he said the evils of opium were grossly exaggerated, that its use in moderation was not injurious, and that it would be an injustice to destroy one of India's greatest industries. Sir Lepel Griffin considered it the life blood of Central India, its prohibition disastrous to finance and to any government popularity. Against this a missionary lately returned was strong on the iniquity side.

Thyroid juice is recommended by Dr. Richardson, to be prepared by placing three lobes of the thyroid gland from a freshly killed sheep in a bottle containing a half per cent solution of carbolic acid and thus transporting them to the laboratory. There the capsules are carefully and completely stripped, the glands thinly sliced on a sterilized slab, and placed with forty-five minims of a half-per-cent solution of carbolic acid in a conical two-dram measure, this being covered over with a piece of sterilized blotting-paper. The following day the mass is squeezed through a piece of well-boiled cambric, the resulting sixty minims or so of turbid fluid being then reckoned as four doses. Dr. Richardson is always most careful to sterilize the hands and instruments by the use of one in twenty carbolic solution.

Arrangements are soon to be made by the Local Government Board for an investigation into the connection or relation between cholera nostras and true Asiatic cholera. The inquiry will not be intrusted exclusively to the officers of the board, and will include the clinical, epidemiological, and bacteriological aspects of the maladies concerned. It is considered on all hands that during the whole course of the epidemic the work of the Medical Department of the Local Government Board has been done with most scrupulous care and thoroughness. The difficulty in this country has been to distinguish true Asiatic cholera and the often extremely similar disease of domestic origin.

Among the Parliamentary papers just issued is the report of the Select Committee appointed to inquire into the sufficiency of the existing law as to the disposal of the dead, for securing an accurate record of the causes of death in all cases, and especially for detecting them where death may have been due to poison, violence, or criminal neglect. Among various recommendations it is thought that in no case should a death be registered without production of a certificate of the cause of death signed by a registered medical practitioner, or by a coroner after inquest, or in Scotland by a procurator fiscal. That in each sanitary district a registered medical practitioner should be appointed as public medical certifier of the cause of death in cases in which a certificate from a medical practitioner in attendance is not forthcoming. That medical practitioners should be required to send certificates of death to the registrar instead of handing them to the representatives of the deceased. That the practice of burial in pits or common graves should be discontinued. That still-births which have reached the stage of development of seven months should be registered upon the certificate of a registered medical practitioner, and that it should not be permitted to bury or otherwise dispose of the still-birth until an order for burial has been issued by the registrar.

Some recent observations in the use of sulphate of cinchonidine have proved it to be as effective as quinine in intermittent fever, and also valuable in its effects against anemia and visceral engorgement caused by malaria. The disappearance of the active symptoms occurs usually on the second day, sometimes it is said on the first. The dose is fifteen grains, and is generally sufficient. The physiological effects are less marked and less frequent than with sulphate of quinine. The expense is also much less.

Injections of strychnine in cholera have been given by an army medical officer in India with marked success with the hypodermic syringe. The treatment has been tried in some hundred of cases when collapse has set in, or seems to be coming on; five minims of the liquor strych. in an equal quantity of water is administered night and morning, and in some cases more frequently. When the urinary secretion has not been re-established within twelve hours or so of the cessation of the other symptoms, hypodermic injections of pilocarpine are employed with marked success.

Abstracts and Selections.

CHLORALOSE.—In a monograph recently published in Paris, Dr. A. Goldenburg has described the physiological and therapeutic action of "Chloralose," together with sixty-four clinical observations taken from hospital records and notes of private cases. This drug, which seems destined to replace in a great measure other hypnotics, consists of a combination of anhydrous chloral and glucose, and was first discovered in 1889 by Helter. It crystallizes in fine needles, which are but slightly soluble (five grams in a liter of warm water), and extremely bitter to the taste. It is usually prescribed in cachets or "perles," but in cases when this method of administration is not practicable it can be given in liquid form:

R Chloralose, 0.30 gram;
 Water, } āā 50 grams. M.
 Syrup of mint, }

If given in this form, the water must be heated, and the potion should be freshly prepared each night.

It is an extremely active drug, and does admirable work in cases of simple insomnia. Neither heart disease nor any digestive trouble are considered counter-indications to its use. It produces refreshing sleep, and is far more certain in its effects than sulphonal, paraldehyde, urethane, etc., while it is apparently free from the very objectionable characteristics of morphia and chloral. There is no "habit" formed, and, so far as known, no increase of dose is required when it is necessary to give the drug for several successive nights. In short, it is believed to be entirely safe when given in proper quantity, and far surer than other hypnotics in cases where no pain is present.

The medium dose for an adult is twenty centigrams, although it has been given in an aggregate dose as large as two and a quarter grams in a single night without accident. The usual mode of administration is to give a cachet of twenty centigrams an hour before the expected sleep, and repeat once during the night in case the result is insufficient. The only case in which disagreeable symptoms (headache, trembling, trouble of vision, oversomnolence) have been observed were those of hysteria, alcoholism, or organic nervous affections, and in such instances a continuation of the drug in modified dose has given good results.

The first samples of this new remedy which have reached America were received May 22d, and thus far I have had opportunities to judge its effects in three instances only, in each of which, however, it has fully justified the reputation it has acquired in Paris during the past spring.

Case 1. May 31, 1893. A. B., an extremely nervous woman, forty years old, seen the day after an eruption of measles had appeared. Always a poor sleeper, and at the present time unusually excited by the fact of her illness, which interferes in many ways with her comfort and produces a number of complications in family affairs. Twenty centigrams of chloralose were given at 9 P. M., and the dose repeated an hour later, with the result of a calm and refreshing sleep of nine hours' duration. Since then a single cachet of twenty centigrams has produced an average of nine hours' sleep without the slightest disagreeable after-effects.

Case 2. June 7th. P. R., age seven. A case of organic congenital nervous trouble, into the details of which it is useless to enter. Restless nights have always been a source of great discomfort to the child and his attendants. Bromide and sulphonal (ten grains and three grains each, respectively) produce only slight effects. Ten centigrams of chloralose were given without any beneficial results. On June 8th twenty centigrams produced a quiet sleep of eleven hours' duration. Dose reduced to fifteen centigrams.

Case 3. June 8th. L. C., age fifty-eight, a neurasthenic woman, in whose case sulphonal does only moderately good work. A single dose of twenty centigrams of chloralose produced eleven hours of refreshing sleep. On June 9th the dose was reduced to fifteen centigrams, which proved sufficient to give perfectly good nights with sleep averaging between nine and ten hours.

The drug was first brought into prominence by MM. Hanriot and Ch. Richet in January last. These gentlemen presented the results of their researches before the Société de Biologie of Paris, and gave details of a series of most interesting experiments on animals. Clinical research shortly followed, and so far as can now be judged we have come into possession of a very valuable addition to our list of hypnotics. The drug will not be obtainable here for a fortnight at least, as I am informed by a patient that he has purchased what was said to be the last of the extremely limited supply which has thus far reached America.—*Dr. F. G. Morrill, Boston Medical and Surgical Journal.*

SULPHONALISM.—The presence of hematoporphyrine in the urine appears to indicate a certain degree of disorganization of the red globules of the blood, and is usually connected with some disorder of the liver or other hematopoietic organ. It is a red coloring matter experimentally obtained by the action of concentrated sulphuric acid on the hemin of the blood, and its clinical importance here is that its presence seems to be one of the results of the continued administration of certain drugs, sulphonal in particular.

Two or three recent papers by Salkowsky and Hammarsten have called attention to this fact, which seems to have been noticed as early as 1889 by Stockvis, and in 1890 by Rankin and Pardington. The discoverer of this

substance, Neucki, from experiments on rabbits, concluded that it was non-toxic, but Salkowsky believes the contrary as regards the human species.

In any case it indicates a considerable general disorganization of the hemaglobin of the blood.

He estimated the quantity eliminated daily in the urine of which he examined samples as .87 grams, which would necessitate the disorganization of 18.5 grams of hemaglobin, or one thirty-second of the whole average quantity contained in the blood.

In Hammarsten's cases it appeared that the red urine followed the long continued use of the drug in one after 106 grams had been taken in daily doses of one or two grams. It regained its normal color nine days after cessation of the treatment. In another 84 grams had been taken at the same daily rate, and the urine was of the color of red wine.

It was normal after fifteen days' intermission of the treatment, and again red on its renewal after the administration of six daily doses.

It would seem, therefore, that we have here a contra-indication to the long-continued usage of sulphonal, that it disorganizes the blood, and certainly, in this light, a means of recognizing its overuse.—*Boston Medical and Surgical Journal*.

A MEANS OF RELIEF IN HAY-FEVER.—The capriciousness of hay-fever and the occasional relief obtained from an entirely empirical method of treatment warrant the publication of any means which has proved successful, in the hope that it may be of use to some other person afflicted with this annoying and disabling disease.

Ferber, of Hamburg, reports his own case, which had been so severe as to necessitate his using a closed carriage all through the summer. His relief was brought about from accidentally noticing that in the winter a coryza was usually accompanied with hot ears which regained their normal temperature when the discharge from the nose was established. He determined to try a reversed order of effect on the hay-fever in the summer, and began accordingly to rub his ears until they became red and hot.

It is now the third year that he has been able to lead an endurable existence during the hay-fever season. "As soon as the least sensation of fullness in the nose appears, there is recognized a certain amount of pallor in the ears. A thorough rubbing of the ears, at times even to contusion, has always succeeded in freeing the nasal mucous membrane from its congestion. The rubbing, however, must be thorough and repeated as often as the least symptom of congestion returns to the nose. Since using this means I have been able to take long sandy walks, sit and even sleep with open windows or pass an evening in my garden without distress. Several patients have had the same relief from this treatment, always in proportion to the thoroughness of the rubbing, and I hope by this means some other physician may be able to give his patients the same great relief."—*Ibid*.

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"NEC TENUI PENNÂ."

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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AMPUTATION AT THE HIP-JOINT.

A paper by Prof. Murdoch, in the Annals of Surgery (January, 1893), a minor paragraph quoting Murdoch, in the New York Medical Journal of November 4th, the comments upon the same by Dr. John A. Wyeth (New York Medical Journal, November 11th), and a paper published elsewhere in this issue (page 453) again remind us that this formidable operation has a remarkable history in which American surgery, through Southern surgeons, plays the leading part.

Dr. Wyeth writes:

While a minor paragraph of your issue of November 4th, upon the subject of the amputation at the hip-joint, is mainly correct in the lines quoted from Professor Murdoch's excellent paper in the Annals of Surgery (January, 1893), the construction of the paragraph is, I think, calculated to mislead. Professor Murdoch says: "It was reserved for our countryman, Dr. John A. Wyeth, to devise what he has well named the bloodless method. I believe this method to be the best and the one destined to supersede all other methods for the temporary arrest of hemorrhage."

The method of operating known as that of Fourneaux-Jordan, referred to in your paragraph, has *nothing to do with the prevention of hemorrhage*, but relates to the method of making the flaps.

This same method of cutting the skin and soft parts is also frequently referred to as Diefenbach's. The truth is that Diefenbach did not receive his degree in medicine until sixteen years after Dr. Walter Brashear, of Kentucky, had done this operation successfully. "A circular incision was made, the muscles divided well below the hip-joint, and the vessels secured as the operation progressed. Then a longitudinal incision along the outer

side of the limb exposed the remainder of the bone, which, being freed from its muscular attachments, was disarticulated at the socket." This was in August, 1806 (*American Practitioner and News*, Prof. David W. Vandell, 1890). The name of Brashear should forever be associated with this brilliant operation.

Dr. Wyeth quotes from Dr. Vandell's address at the 1890 meeting of the American Surgical Association two sentences descriptive of the technique of Brashear's operation. Since the historical features of this part of the address give it conspicuous interest at this time, we quote the section in full. Dr. Vandell said:

The earliest original surgical work of any magnitude done in Kentucky, by one of her own sons, was an amputation at the hip-joint. It proved to be the first operation of the kind in the United States. The undertaking was made necessary because of extensive fracture of the thigh with great laceration of the soft parts. The subject was a mulatto boy, seventeen years of age, a slave of the monks of St. Joseph's College; the time was August, 1806; the place, Bardstown; the surgeon, Dr. Walter Brashear; the assistants, Dr. Burr Harrison and Dr. John Goodtell; the result, a complete success. The operator divided his work into two stages. The first consisted in amputating the thigh through its middle third in the usual way, and in tying all bleeding vessels. The second consisted of a long incision on the outside of the limb, exposing the remainder of the bone, which, being freed from its muscular attachments, was then disarticulated at its socket.

Far-seeing as the eye of the frontiersman was, he could not have discerned that the procedure by which he executed the most formidable operation in surgery came so near perfection that it would successfully challenge improvements for more than fourscore years.

Hundreds of hips have since been amputated after some forty different methods; but that which he introduced has passed into general use, and (though now known under the name of Fourniaux-Jordan's) remains the simplest, the least dangerous, the best.

The first genuine hip-joint amputation executed on living parts was done by Kerr, of Northampton, England, 1774. The first done for shot wounds was by Larrey, in 1793. I feel safe in saying that Brashear had no knowledge of either of these operations. He therefore set about his work without help from precedent, placing his trust in himself, in the clearness of his own head, in the skill of his own hands, in the courage of his own heart. The result shows that he had not overestimated what was in him. But whether or not Brashear had ever heard or read a description of what had been accomplished in this direction by surgeons elsewhere, the young Kentuckian was the first to amputate at the hip-joint in America, and the first to do the real thing successfully in the world.

Dr. Brashear seems to have set no high estimate on his achievement, and never published an account of the case. Had he done so, the art of surgery would thereby have been much advanced, his own fame would have been made one of the precious heritages of his country, and, what is better, many valuable lives would have been saved.

Eighteen years after the Jesuits' slave had survived the loss of his limb the report of the much-eulogized case of Dr. Mott appeared.

Such is the history of a surgical feat in which, perhaps, next to ovariectomy, Southern surgery may be pardoned for the exhibition of a somewhat enthusiastic self-esteem. To a Kentuckian belongs the honor of devising a method by which the operation might be successfully done; but it was reserved for an Alabamian (a graduate of the University of Louisville) to bring the operation to technical perfection by setting aside its chief stumbling-block, hemorrhage. While it is right that "the name of Brashear should forever be associated with this brilliant operation," it is certain that the name of Wyeth is worthy to be likewise so associated.

Notes and Queries.

TREATMENT OF LOSS OF SEXUAL POWER BY LIGATION OF VEINS.—The loss of sexual powers, says Dr. Alfred King, or rather deficient erections of the penis, render so many men miserable mentally and physically that any new method of treatment promising a radical cure merits investigation and trial.

Three immediate causes of deficient erections may be specified: destruction of the erector muscles, loss of nerve power, and a change in the circulation. The first of these is so rare and so easily determined that it needs only a passing notice. The second cause, loss of nerve power, seems to me to have received more prominence than it deserves, as it is the basis on which almost all treatment is founded. While its force in many cases is undisputed, yet the frequent failure of treatment based upon it leads me to direct attention to the importance of the third cause, that is, a change in the circulation. This change takes place in the veins, especially those which do not pass beneath the pubic arch or are not acted upon by the erector muscles. Repeated engorgement of the penis renders their caliber larger, and, consequently there is a more rapid escape of blood through them. When, therefore, an erection takes place, it can not be maintained on account of the escape of blood through these channels. Thus we have the history of

gradual shortening of the duration of erections, and finally scarcely none, if any, as these veins grow larger.

The remedy for such a condition, especially when far advanced, is not in the use of drugs, but may be brought about speedily and safely by the ligation of some of the larger of these veins.

The following case is given to illustrate this cause and its successful treatment:

Mr. M., aged thirty-five, a laborer of powerful physique, came to me about a year ago with the following history: For several years he had been losing the power of maintaining an erection; during the past year its duration had been so short that sexual intercourse had been rendered impossible. There was a loss of sexual desire and great mental depression. Excessive use or abuse was the cause of this condition.

I gave all possible encouragement to the patient; advised total abstinence from sexual intercourse, cold baths (especially to the spine and external genitals); prescribed bromides, cannabis indica, cantharides, damiana, phosphorus and salts containing it; pushed strychnine as far as it could be borne; gave various tonics; used electricity; and in short did every thing which offered any hope of success, but all to no effect so far as producing any stronger erections was concerned.

Careful study of the case convinced me that the immediate cause of the trouble was a physical one, due to a leakage, as it were, or to a too rapid escape of blood from the penis when erected. I therefore determined to ligate a couple of the largest subcutaneous veins at the base of the penis and watch the effect.

This was very easily done by the use of cocaine. A vein on each side of the penis was exposed, ligated in two places and severed between the ligatures. A dressing was lightly applied, and held in position by a strip of adhesive plaster placed longitudinally. The result was immediate. In less than five minutes after leaving my office he had an erection. That night he was awakened by a powerful erection, which made the bandage so painfully tight that he was obliged to jump out of bed on to the cold floor to subdue it. Primary union was prevented by the frequent erections, but the success of the operation was certain.

Two months later he reported himself well, mentally and physically, his sexual appetite had returned, and since the operation his power of maintaining erections had been good as ever.—*Boston Med. and Surg. Journal.*

BACILLUS BILLET-DE-BANQUUS.—Acosta and Grand Rossi have been studying the bank bills of Havana and the microbes deposited thereon. They found that the weight of the bills actually increased during their circulation because of the sweat, grease, and dirt deposited upon them. In these deposits thrive the microbes. In two cases the number of microbes exceeded nineteen thousand upon the surface observed. Among these microbes there was one bacillus which appeared special, and which has

been named *Bacillus billet-de-banquus*. It is septic. Inoculated in rabbits and guinea-pigs, it caused them to die rapidly. There were also found the bacilli of tuberculosis, of diphtheria, and the streptococcus of erysipelas, as well as several other pathogenic forms.—*American Microscopical Journal*.

THE LUXURY OF EXPERT SURGERY.—The demand for the services of the best-known and consequently expensive surgeons of London, says the Medical Press, has never before fallen to such a low ebb. Whatever the reason may be, it appears to be affecting consulting physicians as well. Men who have in former years made large incomes and incurred corresponding expenses are looking forward with doubt as to what the future will bring, especially as there now seems to be a highly satisfactory standard of the public health.

NEW YORK'S MILK SUPPLY.—The inhabitants of New York consume, it is said, a great deal of beer and a reasonable amount of Croton water, but they do not neglect milk. Over 900,000 quarts are delivered daily, making an annual consumption of 329,500,000 quarts, or 82,325,000 gallons.

Special Notices.

SULFONAL IN FEVERS.—In a recent article on typhoid fever Dr. Crutchfield said: "Sulfonal is of service in relieving the insomnia of this condition." Dr. Bond praises its action in typhus fever, adding, "In sulfonal we have a drug which may be safely administered to combat insomnia arising from gastric diseases." Dr. Marcus recently said: "In acute fevers accompanied by insomnia, sulfonal produced six hours of sleep." He further stated: "One case of a man, fifty years old, under my treatment had suffered nearly three months with insomnia. Bromides, chloral, and morphine had no effect whatever. I prescribed sulfonal, fifteen grains. In two hours the patient fell asleep for four hours, and, after being awake for one half hour, slept again until morning. The next evening I prescribed twenty grains, which produced a seven hours' sleep."

Dr. Baird relates that in the severest case of typhoid fever he had ever attended he had vainly tried to produce sleep by the use of "chloral, the bromides, camphor, valerian, and other hypnotics." He then gave a twenty-grain dose of sulfonal, and the patient slept until 3 A. M. "Another dose of sulfonal was given," says Dr. Baird, "when she slept soundly until 7 A. M. In this case sulfonal was the hypnotic." Dr. Duffey writes: "In enteric fever, with insomnia, twenty-five grains of sulfonal upon three successive nights produced three and a half hours, eight hours, and six hours quiet sleep, with no bad after-effects."

WILLIAM R. WARNER & CO. GIVEN THE HIGHEST COLUMBIAN AWARD.—(Special to the Inquirer.) Chicago, October 13, 1893. W. R. Warner & Co., of Philadelphia, have obtained the highest prize for the purity and perfection of their medicinal and official standard pharmaceutical and chemical products.

This extensive firm have obtained hitherto twelve grand World's Fair prizes, and they must feel deservedly proud of the Columbian award, which is the highest of its class.

THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNĀ."

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No. 13.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Articles.

CLONIC SPASM OF THE CERVICAL MUSCLES.*

BY H. A. COTTELL, M. D.

Professor of Medical Chemistry, Microscopy, and Clinical Diseases of the Nervous System, University of Louisville.

The patient whom to-night I present is Mr. W. M., aged forty-two years, white, married. His childhood was healthy. From the age of fourteen to thirty-one he did heavy work in a rolling-mill. After this he entered the police service of his town, and later was made city marshal, which office he held till his present condition forced him to give it up.

At the age of twenty-eight years his physician made a diagnosis of diabetes in his case, but whether mellitus or insipidus I can not learn. The disease lasted one year, when the patient recovered his health, which remained unimpaired till two years ago. An examination of his urine to-day shows that fluid to be normal. The patient was a hard drinker for a period of five or six years previous to the attack.

The present trouble began two years ago. The patient first noticed a slight jerking of certain muscles on the left side of the neck (sternocleido-mastoideus and trapezius). This spasm was steadily progressive until the action was strong enough to draw the muscles intermittently to the right side (clonic spasm).

There is no pain. The appetite is good and the digestion fair, while the bowels are regular. There is slight headache at intervals. The patient has lost forty pounds in flesh since the beginning of his attack. The hearing and sight are unimpaired. The pupillary reflexes are normal.

*Read before the Louisville Medico-Chirurgical Society, October 27, 1893. For discussion see p. 502.

The patella tendon reflex is physiological. There is no ankle clonus. There is no history of syphilis. Spinal degenerative disease is excluded.

The principal muscles involved are the left sterno-cleido-mastoid and left cervical portion of the trapezius, but close observation will show that the right platysma, right omo-hyoidens, right splenius capitis, and right levator anguli scapulæ, with possibly some of the deeper muscles, such as the trachelo-mastoid and the complexus, take part in the spasm.

Excluding local (post-hemiplegic) chorea and the spasm of pachymeningitis, we have here a case of chronic wry neck, the spasm being clonic instead of tonic, as perhaps we more commonly see it in practice.

Spasmodic torticollis is more common in women than in men, the proportion being about seven of the latter to seventeen of the former. (Gowers.) It generally begins in the middle period of adult life, between thirty and fifty years of age. It is rare under thirty, and seldom occurs after fifty, in most cases occurring in females under thirty, and in some rare cases in boys the phenomena are hysterical.

A neurotic heredity or a previous neurosis in the patient predisposes to the affection. Melancholia, habit spasm, depression of general health, a blow upon the head, exposure to cold, rheumatism, excessive use of the muscles concerned (as in certain occupations), and malaria have all been credited with producing the disease in many cases, while in some it has come on in perfectly healthy subjects without apparent cause.

Symptoms. Pain or a sense of uneasiness usually precedes the spasm, but in some cases spasm is the first symptom observed. Sometimes the sensations are vertiginous, the patient being dizzy or manifesting a tendency to deviate to one side when walking. Sometimes the head is bent backward (retro-colic), and again it is simply rotated to one side, as in the case exhibited to-night.

The symptoms vary according to the number of muscles involved. Usually a number of muscles are in the spasmodic state; rarely one muscle only may be involved. The head deviates more frequently to the left than to the right side, the proportion being about 13 to 7.

The muscles most commonly involved in the spasm are the sterno-cleido-mastoid, the trapezius, the levator anguli scapulæ, and, more rarely, the splenius, complexus, trachelo-mastoid, digastricus omo-hyoid, and sometimes the platysma.

Sometimes it is difficult to say just what muscles are involved. In the case exhibited the levator anguli scapulæ, omo-hyoid, and splenius capitis et colli on the right side seem to take part in the spasm, while

the sterno-cleido-mastoid and the trapezius of the left side are undoubtedly the prime movers in the rotation of the head. These muscles turn the head to the side opposite to that of their attachment, and are seen to be strongly contracting when the spasm is on. The other muscles mentioned tip or rotate the head to the side on which they are attached, and if, as it looks to me, they take part in the turning of the patient's head, the present case is one of bilateral spasm. Such cases, though rare, are occasionally encountered.

Pathology. No lesion of the cord or irritative centers of the cerebral cortex has as yet been found associated with cervical muscular spasm. From what is known of the nature of allied diseases, especially facial spasm, it is probable that the disease is due to overaction of certain cells in the cerebral cortex or perhaps lower centers.

Dr. Berkeley found* *post-mortem*, in a case of persistent clonic facial spasm, "a small focus of softening in the ascending frontal convolution opposite the origin of the fissure between the middle and lower frontal convolutions." By analogy a clonic torticollis would cause us to look for similar lesions in the centers concerned in movements of the neck, but no dead-house investigation has as yet brought such lesions to light. Cortical lesion has produced spasm in certain cervical muscles, but such spasm has usually been associated with conjugate deviation of the eyeballs. "In ordinary torticollis, however widely the spasms spread, the muscles of the eyeball are not implicated." (Gowers.) The pathology of torticollis remains an unsolved problem, as is the case with most other spasmodic affections.

Diagnosis. Torticollis is to be distinguished from post-hemiplegic chorea, the spasm of pachymeningitis, false torticollis, simple tremor, and hysteria. The first is excluded in our case by the clinical history (no hemiplegia); the second by the absence of pain, the third by absence of signs of diseased cervical vertebra and absence of tension in the sterno-cleido-mastoid of the side to which the head is bent or turned, the fourth by the decidedly spasmodic action of the muscles concerned, and the fifth by the sex and age of the patient, and by the fact that the spasm is always limited to the muscles of the neck.

Prognosis. In well-developed cases, especially when the spasm affects invariably the same muscle or muscles, and when the patient is past middle life, the prognosis is very unfavorable. I am sorry to say that these points obtain in the present case.

*Gowers: A Manual of Diseases of the Nervous System, second edition, volume 2, page 251. P. Blakiston, Son & Co.

Treatment. The treatment employed in this case, which has been under my care for three months, has been small doses of potassio-mercuric iodide and iodide of potassium, ten to thirty grains, three times a day. Tincture of gelsemium in medium doses has also been given, with tonics and reconstructives as they seemed to be indicated, but my principal endeavor has been to test the power of electricity in the case. For a period of about six weeks static electricity by spark and by breeze was applied to the affected muscles on an average of three times a week. This was without effect. For the next six weeks a current of galvanism (ten to fifteen milliamperes, anode under occiput, cathode, labile, and stabile over the affected muscles) has been applied with about the same frequency. Result so far negative. Faradization of the opposing muscles, though recommended by good authority, seemed to be unscientific, and was not applied.

My chief object in reporting and presenting the case is to get the opinions of the surgeons present as to the feasibility of a neurectomy of the spinal accessory nerve, or perhaps a tenotomy of the muscles involved. The first measure has been effective in a few cases. The second seems only to have increased the discomfort of its victims. Both have been recommended to my patient.

LOUISVILLE.

CHRONIC INFLAMMATION OF THE TONSILS.*

BY L. S. GIVENS, M. D.

Physical evidences of chronically enlarged and inflamed tonsils are so easy of detection that I deem it hardly necessary to describe at length the subjective signs. Both chronic inflammation and hypertrophy of the tonsils are generally met with in children and in the earlier years of adult life, there being a gradual tendency of these organs to disappear after the thirtieth year. There are several exceptions, however, to this general rule, and cases have been seen where the hypertrophy had disappeared, and enough of the gland or glands had been left to occasionally become inflamed, and in one case, that of a middle-aged maiden lady, the tonsils were inflamed to such a degree—with several points of cryptic obstruction and severe pain experienced in swallowing—that a very alarming diagnosis of cancer had been given by the con-

*Read at the May Meeting of the Kentucky State Medical Society.

sulting physician, which was not confirmed, however, by a later diagnosis and a future history of the case.

Chronic inflammation may result as the remains of an acute inflammation, or it may be due to a chronic disease of the lacunæ of the gland, leading to obstruction of the crypts, with hypertrophy of the parenchyma. Chronic lacuna tonsillitis does not necessarily imply glandular enlargement, and absence of hypertrophy is the reason why such cases are so obstinate of cure. A scrofulous diathesis predisposes to inflammation of the tonsils, and in acute tonsillitis there may have been diphtheria, scarlatina, and the like, which can produce the enlargement spontaneously.

In acute tonsillitis the value of differential diagnosis is important, as the diseases that may be confounded with the acute tonsillar inflammation may be those I have just mentioned, that is, diphtheria, scarlet fever, where the rash is ill-developed, syphilis, cancer, or, perhaps more frequently than any other, phlegmonous pharyngitis. But in chronic tonsillitis we have not these differences to deal with, and we often make a diagnosis of chronically enlarged tonsils before looking into the throat. The characteristic thickening of the voice where there is hypertrophy, the speaking as with the mouth full, and the derangement of the whole respiratory tract, for the air in the upper air-passages passes over a very unhealthy surface, are sufficient to warn one what to expect when the mouth is opened. When enlargement of the glands is considerable the lungs are not fully aerated, the chest walls are never fully expanded, and from the inactivity of the latter they become narrow and shrunken, giving the breast-bone an undue prominence. This deformity is not exaggerated, and that form called "pigeon breast" is a familiar one to every doctor. Imperfect oxygenation is a natural consequence, and the child attains maturity (if measures are not taken to prevent it) in a very weak and debilitated condition.

Cough is not a common symptom, yet I have seen three cases of severe spasmodic cough due to the reflex irritation from enlarged tonsils. Two of the cases were seen in the clinic of Mr. Lennox Browne during my stay in the Central London Throat and Ear Hospital a few years since. One was in a little girl of eight years, who was continually given to "hawking" and "hemming," the cough being dry and without expectoration, occurring with violence at times, before, during, or after a meal even, and would cough and choke until she vomited. This latter would relieve her only for a short time, however, and the cough con-

tinued distressing enough until she became weak and emaciated. This state of affairs had existed about six months when the child was brought to the hospital. Examination revealed nothing abnormal in the general condition, except the vault of the pharynx, which was nearly filled with hypertrophied tonsils. Their complete removal succeeded in stopping the cough; appetite returned, the child's expression brightened, and in a comparatively short time there seemed to be complete restoration to health.

The second case was similar; the age of the boy was twelve, and he had in addition the scrofulous diathesis. The removal of the tonsils cured the cough, and appropriate remedies greatly improved his general health. The third was a case in my own practice. Henry F., aged nineteen, a student, had suffered ten years with a harassing cough, disturbing at night, persistent by day. He had very reluctantly parted company first with his appetite, then with his flesh, and had been for two years very much emaciated and troubled with hysteria. He had been dosed systematically from time to time for stomach cough, tooth cough, liver complaint, tape-worm, thread-worms, consumption, and so on. His tonsils were chronically enlarged, and would take on acute inflammation about twice every season. After considerable persuasion he agreed that I should amputate them, and since their removal the cough has disappeared, appetite and flesh have returned. This operation might have been made years before, affording him great relief. I thoroughly believe in the early active treatment of hypertrophied tonsils in children; for, if there is a likelihood of the disappearance of the glands in after years, ought we to wait for this, let the child outgrow it, as it were, in the mean while allowing the senses of hearing, smell, and taste to become perhaps permanently impaired?

I have taken considerable interest in chronic throat diseases—though not a specialist—and in no class of cases do I know of having given more permanent relief than in thirty or more cases in which I have removed the organs entire where they had been the cause of all the trouble. The treatment of chronic lacunar disease is very unsatisfactory where there is no hypertrophy. I have found the best treatment for them to be the squeezing out of the thickened, cheesy secretions from the crypts, and the application of the galvano-cautery tip to the cavities. This may be done once in every two weeks until four treatments have been given, which will usually suffice for a time. Between treatments, lozenges, or tablets of guaiacum comp., as manufactured by the

Frazer Tablet-Triturate Company, will be found very serviceable. Morell Mackenzie recommends London paste applied once or twice a week over different parts of the inflamed organ. Sajous thinks well of the introduction of a portion of the solid stick nitrate of silver, on a heated wire, into the lacunæ of the tonsils. Others recommend crystals of chromic acid for the same purpose. Electrolysis is good, but entirely too tedious and troublesome. Occasionally this non-hypertrophic condition will take on active inflammation and enlargement ensue, which, if sufficient, should cause the tonsils to be removed, as would be done in regular hypertrophy.

As to the treatment of chronic enlargement of the tonsils, the most satisfactory method is the one of excision. The operation is easily performed and is accompanied with but little pain. The bistoury makes sure work of the gland, but there is danger of cutting the surrounding parts. The usefulness of the wire snare is almost limited to such glands as grow along the side walls of the pharynx, and can not be induced to enter the ring of the tonsillotome. I had learned to use Mackenzie's tonsillotome, but recently have used Mathieus', which is much more convenient to handle and performs its mission more satisfactorily, from the fact that it is easier to pull with the fingers than to push with the thumb. Again, the Mackenzie tonsillotome requires the aid of an assistant to hold the head and at the same time to press in the gland from without on the side of the expected operation. With Mathieus' one can operate without assistance. The instrument is introduced flatwise into the mouth until the enlarged gland is reached. A turn on its axis to the right or to the left brings the ring over the organ to be excised. If the thumb is now pressed forward, the fork extending the length of the instrument will penetrate the gland, and, beside holding it in a fixed position, will elevate it to any desired degree.

The thumb and finger rings may now be approximated, and the tonsil is guillotined, the excised portion remaining on the fork. The instrument, if necessary, can be quickly placed in position and again introduced for an operation on the opposite side. Slight bleeding occurs after the amputation, and I have the patient to gargle well with ice-water. It is well to have prepared at the time, in case the ice-water does not stop the bleeding, a mixture of tannic and gallic acid, six drams of the former and two drams of the latter in one ounce of water. This makes a thick mixture instead of a solution, and is to be sipped at intervals of five minutes or less. The suggestion of Sajous is a very

important one, that of injecting a strong solution of cocaine into the parenchyma of the tonsil prior to operating. It produces an exsanguine condition of the organ, prevents even the usual slight bleeding at the time of the operation, and renders the patient less liable to subsequent hemorrhage. According to authorities on the subject hemorrhage seems to be a rare occurrence, but may be profuse and even alarming. I give the exact language of Lefferts, who has had great experience in this direction, and who takes rather a serious view of the question: "That though the operation of tonsillotomy thoroughly performed is usually unattended by untoward result, still it is not free from alarming, sometimes dangerous results; and that, though these be the exception, they should not be ignored; and that the surgeon must always be prepared both mentally and physically to cope with a hemorrhage that may unexpectedly occur."

After-treatment of excision of the tonsils demands a moderate amount of attention. I prescribe an antiseptic gargle of a dram each of salicylic acid and chlorate of potash to eight ounces of water. This is cleansing and healing to the cut surfaces, which in healthy subjects proceed to get well as fast as they can. Liquid nourishment should be enjoined for a few days. When the scrofulous diathesis is marked, appropriate remedies should be prescribed to combat it. Many inquiries are made to the surgeon as to ill effects likely to occur after the removal of the tonsils: Will the voice be as good as before? Will there be more danger of contracting cold, diseases, and the like? I repeat the words of that most eminent authority on throat diseases, Lennox Browne, "That nothing but ultimate good can follow from the operation of removal of the tonsils in suitable cases."

CYNTHIANA, KY.

A REPORT OF TWO CLINICAL CASES.

BY JAMES B. BULLITT, M. D.

The two following cases are deemed worthy of report; the one because it presents a typical and classical picture, the other because it is an injury somewhat uncommon:

Intussusception. Being called in a hurry to see a girl baby of eighteen months, I found the child lying quietly on the bed, the eyes somewhat sunken, face pallid, bodily temperature less rather

than more than normal, pulse very quick and impossible to count. The mother stated that on the previous evening the child had been in the best of spirits and health, had romped with its father, who among other things had tossed it into the air a number of times. At 4 A. M. the child had evinced uneasiness and pain, vomited a couple of times, and then had an evacuation consisting of a small amount of mucus, clear and streaked with blood. Up to 9 A. M., when I first saw the child, there had been about four of these evacuations. My first thought was of a dysentery, but the stools from the first had contained no fecal matter. After a couple of hours' consideration there came the conviction that only one condition could exist with these symptoms, an intussusception. Careful examination of the abdomen revealed the sausage-like tumor in the left iliac region. The diagnosis of intussusception was at once made and an unfavorable prognosis given. Injections of hot water were attempted with the child reversed, feet up, head down. Almost no water was retained; almost as soon as the flow began from a fountain syringe a return flow set in through the anus around the nozzle of the syringe. Compression of the buttocks around the nozzle availed nothing. The exploring finger could make out the intussuscepted intestinal mass about three inches from the anus. During the day and the next several like attempts were made, always with like failure. It was then concluded to allow the child to expire in peace and with as much comfort as might be, so whenever it evinced pain opium was given, and it was so kept quiet. Vomiting occurred at intervals for the first two days and then ceased. The matter vomited consisted of mucus and water, which the child took with avidity. There was no fecal matter. The small, clear mucous stools streaked with blood continued at intervals. On the third day there were voided two small pieces of tissue about the size of twenty-five-cent pieces. These on examination appeared to be portions of mucous membrane which had sloughed off. At the same time the stools became offensive, putrescent. On the fourth day death occurred, according to program, and my reputation with the family was saved. In spite of urgent request no *post-mortem* examination would be permitted. "The child had never been cut while alive, and they would bury it without being cut, too." Some people die, and others should be killed.

Fracture of the Coronoid Process, with Dislocation Backward of Both Bones of the Forearm. This case is reported only because a reference to various text-books proves it to be one of rather rare occurrence. A

boy of thirteen years, while wrestling with a school companion, fell backward; attempting to catch himself, the brunt of the fall was sustained by the ulnar side of the left hand. Something popped, and the doctor was sent for at once. On arrival a few minutes later I found the forearm hanging perfectly limp and freely movable in all directions. The humerus was intact, likewise the olecranon process; below and in front of the end of the humerus could be felt a slight prominence, manipulation of which elicited crepitus. Ulna and radius were both dislocated backward. In the region of the internal condyle was a soft, fluctuating tumor, evidently extravasated blood. Reposition was readily effected under chloroform, and the arm fixed at a right angle in pasteboard splints. These were removed and renewed in a week; in ten days passive motion was begun, and in two weeks splints were removed and active motions undertaken. Now, two months since the injury, extension is complete, and flexion to an angle of about forty-five degrees. There remains a slight fullness about the joint, but in other respects it is as good as its fellow.

GLOBE, ARIZ.

Reports of Societies.

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.*

Stated Meeting, October 27, 1893, Dr. T. S. Bullock, Vice-President, in the chair.

Dr. W. O. Roberts (Case of Epilepsy): This young man three years ago received an ugly wound on the outer side of the arm. Shortly after it healed he had an epileptic attack, and he has been having similar attacks at intervals ever since. The only question of interest is to know whether or not this cicatrix has any thing to do with the causation of the epilepsy. The cicatrix is not sensitive, not painful, and there has never been any thing referable to the cicatrix.

I have seen a number of cases of epilepsy that originated from peripheral irritation due to a cicatrix, especially those about the scalp, but in all of them there was more or less sensitiveness about the cicatrix. There was none about this case, therefore I believe that the cicatrix has nothing to do with the epilepsy.

* Stenographically reported by C. C. Mapes.

DISCUSSION.

Dr. H. A. Cottell: I take it that this is a case of epilepsy coincidental with the healing of the wound. Of course it may be only a theory that it is a reflex epilepsy due to injury of the circumflex nerve, perhaps the internal cutaneous. The wound was very much deeper than you might imagine from the appearance of the cicatrix. It broke out, and there was a furious secondary hemorrhage which the surgeon had considerable trouble in arresting. It is possible that the point of the knife went far enough to wound the brachial artery, but I hardly think so from the position of the cicatrix. There is nothing there that would bleed except some small muscular branches of the brachial. This patient has had epilepsy at rather long intervals, the beginning of which was due to or coincident with the healing of the wound, but the attacks I judge have not been very severe in character. I take it to be a case of epilepsy of a reflex nature; and it struck me that it would be rational therapeutics to remove the cicatrix, since this would not involve any very serious surgical procedure.

Dr. E. R. Palmer: I would like to inquire if there is any specific history in the case. Perhaps that would be a very hard question to determine, but I would suggest that Dr. Roberts look into it very thoroughly.

Dr. Roberts: The patient claims never to have had syphilis.

Dr. J. W. Irwin: This to me is a very interesting case. I am not inclined to believe that the epilepsy is coincidental, as Dr. Cottell has stated, with the healing of the wound, but I think that the wound has brought it about. I believe that the injury of the nerves of this arm by the wound has been the cause of the epilepsy rather than its being coincidental or coming on from some other cause. I remember a few years ago I had under my care a man twenty-two years of age, who while handling a pistol accidentally discharged the weapon, the bullet entering his right arm just about the point where this cicatrix begins, under the anterior border of the deltoid muscle near its insertion, right over the region of the nerves leading down from the axilla. No notice was taken of the bullet; it could not be found, as it was buried under the muscular surfaces, and the external wound healed without any trouble. Four months afterward he was taken with the most intense form of croup. It was not at the season of the year when croup usually occurs. I was sent for in the initial attack,

and administered several remedies with a view of relaxing the condition. It looked more like laryngismus stridulus. Medicines did not have any effect upon it unless I kept him under the influence of chloroform; ether relaxed it even better than chloroform. I treated him several days for this affection of the throat; I could discover nothing but a spasmodic condition to treat; he could not drink without bringing an attack on; could not change his position, could not laugh, could not talk without bringing on a most intense form of spasmodic croup or laryngismus stridulus. I knew nothing of his former injury at this time; later he told me that he was shot in the arm some months before. I then began to look for some reflex irritation as the cause of the trouble. Upon inquiry the history about as above related was elicited. I made an examination of the wound; nothing could be seen but a very small cicatrix slightly depressed, and after lifting the muscle from the bone with my fingers I thought I could feel a little, hard substance. I asked him if the bullet had ever been removed, and he stated that the physician who attended him had never been able to find it; that it had occasioned him no trouble up to that time, and so far as he knew the bullet was still in his arm. I then made a further investigation and found the bullet, which had lodged in the deltoid muscle near its insertion; it had become encapsulated, and was about the size of a hazel nut. I suggested at once the removal of the bullet, believing that it might be the cause of the reflex trouble. He accepted the proposition, and the operation was easily and quickly done. The second day after removal of the bullet the spasmodic trouble disappeared, and four years afterward it had not returned. I would not have been surprised in that case to have seen epilepsy.

Dr. Roberts: Was there any sensitiveness about the cicatrix?

Dr. Irwin: There was no sensitiveness, and nothing to call attention to the cicatrix in this case. So far as reference to the wound is concerned the patient did not know he had a bullet in his arm. To my mind it is a case that would probably go, to some extent, to corroborate the fact that in the case reported by Dr. Roberts the trouble is the result of reflex irritation, there being no history pointing to any other rational cause.

Dr. W. L. Rodman: I agree with Dr. Roberts in the belief that the epilepsy in this case is purely coincidental and has no connection with the wound.

Dr. Palmer (Obstinate Serpiginous Sores): This patient you will recognize as having been before this Society on two previous occasions, suffering from an obstinate ulcer in the groin and a sore on the penis. I have followed the suggestion made by Dr. Rodman the last time I exhibited the case, making an elliptical incision and removing the entire mass of unhealthy tissue in the groin, which, as you will observe, has resulted in almost complete union. The sore on the penis has been treated by, you might say, every known means, and is now in better condition than ever before. I believe the only thing to do is to cut out the whole mass, which may involve going down into the corpus spongiosum.

DISCUSSION.

Dr. Cottell: A patient came to me the other day with a disease involving the lower part of one nostril, which resembles the preputial sore in the case exhibited by Dr. Palmer. The question arising in my mind is whether it may not be a chancroid of the "nose. How a man could get a serpiginous chancroid of the "nose" nobody "knows," but several ways might suggest themselves.

Dr. Palmer: I believe there would have been absolute union of the ulcer in the groin if we had put the patient to bed and kept him there with the leg flexed; but he walked out of the office and reported later as an out-patient. The glover stitch was used in closing this wound; it has healed nicely with the exception, as you see, of a space about three fourths of an inch in length in the center. At the end of a week there was a flesh-like excrescence in the center of the wound looking very much like the original growth. I applied burnt alum to this, and you will observe now the process of healing is almost complete. The specimen removed has been at the University, in Müller's solution, for two weeks, but a microscopical examination has not yet been made. I am almost satisfied that it will prove to be nothing but granulation tissue. I further believe that a careful dissection of this indurated sore upon the penis will result in the same way.

Dr. Rodman: The result obtained in this case is gratifying. When the patient was before the Society, about a month ago, I suggested excision of the unhealthy tissue, bringing the edges together, believing if this were done primary union would result, as seems to have been the case.

As to what the microscope will reveal, I wish to call up the suggestion made, I think, by Dr. Cartledge when the case was last discussed, that the trouble was probably tuberculous in character. The

fact that the trouble has existed for so long a time, the age of the patient, etc., I think indicates its probable tuberculous nature. I would not be at all surprised to find the bacillus of tuberculosis in the specimen removed, though I recognize the difficulty in demonstrating it with the microscope. A great many sections may have to be made before the bacillus is found.

Dr. Roberts (Operation for Removal of Tuberculous Glands): These specimens are nothing more nor less than quite a lot of tuberculous glands removed from the neck of a young lady, twenty years of age, at the University Clinic this morning. The only points of interest in connection with the case are the great number of glands involved, and nearly all of them were in the anterior triangles, many of them very deeply seated, and removed with considerable difficulty. There was very little hemorrhage. The way in which the operation was performed was simply free incision down to the glands, then with a spoon they were scooped out.

DISCUSSION.

Dr. Rodman: Enlarged tuberculous glands nearly always begin in the situation mentioned by Dr. Roberts, the submaxillary triangle. Infection takes place from an abrasion of mucous membrane, socket of a carious tooth, etc., and as the lymphatic vessels of the mouth are directly in connection with the submaxillary lymph glands we have a reason for their being always first implicated.

The essay was read by Dr. H. A. Cottell; subject, Clonic Spasm of the Cervical Muscles, with exhibition of a patient suffering with the affection. [See page 489.]

DISCUSSION.

Dr. J. B. Marvin: I have seen one or two cases much more marked than the one exhibited by Dr. Cottell. The first case was one of a young woman who had been treated by several physicians without much benefit. I understand she afterward fell into the hands of some surgeons, and was operated upon without any decided improvement—a neurectomy by one, and afterward a hysterectomy by another. Another case I saw with Dr. Ouchterlony, which was much more marked than the one shown to-night; there was not only a side movement, but the head was twisted backward and laid on the shoulder.

In regard to the pathology of this trouble I think Dr. Cottell has

given the correct idea, that we know nothing about it. As far as life is concerned the prognosis is favorable. Diagnosis is usually easy.

Concerning the treatment in cases of pure neuroses, where there is no history of syphilis, I think Dr. Cottell did not mention one thing that has been very highly recommended, and which is claimed to give better results than neurectomy, and that is belladonna. Leszynsky, of New York, has published a very interesting article on this subject, in which he claims to have gotten excellent results from the administration of belladonna pushed to point of tolerance. Gray also recommends this treatment in his recent work, and claims to have gotten good results in these cases. I have had very little experience with it, but in the cases I have seen I have tried electricity, etc.; the patients would get better for a while, but no lasting improvement was obtained. I simply suggest belladonna as being much more simple than surgical treatment, and believe it worthy of trial.

Dr. Roberts: It looks to me like a case of chorea. I do not think any surgical interference is called for.

Dr. A. M. Cartledge: Dr. Cottell's paper calls to mind a case that I reported before this Society some weeks ago; it being the case referred to by Dr. Marvin in his remarks, upon whom Dr. Vance subsequently performed an operation for removal of the appendages. That case was very much more marked than the one before us to-night, occurring in a young woman. The spasm was clonic in character, affecting especially the trapezius and the sterno-cleido-mastoid, also the splenius capitis et colli. In that case I resected nearly an inch in the continuity of the spinal accessory nerve, which was followed for the time being with an arrest of all trouble. I believe, if the operation had been followed up with proper mechanical appliances, relief would have been permanent. Operations of this character have been very successful for the relief of torticollis when they have been followed by a brace to hold the head in proper position for a few weeks. In the case I refer to, in the course of a few weeks the spasm gradually commenced again, the same muscles took it up, showing clearly that there was a reunion of the nerve.

The outer border of the sterno-cleido muscle is the place to resect the nerve. The spinal accessory nerve very much oftener passes through this muscle than behind it, and the best place to get at the nerve for resection is about the center of the muscle. The case before us is not an analogous one to the case I saw; I am inclined to look upon

this as more in the nature of choreic manifestations than any thing else; it differs materially from the case I have in mind.

Dr. A. M. Vance: I saw the case mentioned by Dr. Cartledge some time after he had resected the spinal accessory nerve, and am sure there were many more muscles involved than could have been affected by this nerve. The muscles of the abdomen were affected, as were also those between the pelvis and thigh. I removed the appendages, and during convalescence from the operation she was discovered by the nurse to be a masturbator. The patient had been married and was then a grass widow. She was evidently a very neurotic person otherwise than as manifested in the torticollis. She continued to masturbate, excessively I think, and this may have had something to do with the trouble. There is no question that she was considerably improved by removal of the appendages, although they seemed to be perfectly normal.

Dr. Palmer: I think the case before us may possibly be one of specific origin; in the discussion the speakers have overlooked the fact of this man's previous habits, which he says have been those of a hard drinker; they have also overlooked the fact that he has lost forty pounds in flesh.

I do not want to be regarded as a one-idea man, but I believe the treatment in this case should be large doses of potassium iodide, cod-liver oil, and possibly inunctions of mercury to the neck. I think the trouble is due to some pathological change or development somewhere, probably along the spinal accessory nerve. I agree with the idea expressed by Dr. Roberts, that it is not a surgical case.

Dr. C. W. Kelly: I believe it is a case of chorea.

Dr. Irwin: I am quite in accord with some of the gentlemen who have spoken in the opinion that this is largely a choreic trouble of the muscles of the neck, and I think a surgical procedure in this case would be entirely useless if not absolutely harmful. I do not see what could be accomplished by an operation. I remember reading, some years ago, the report of a series of cases (I have forgotten the author) of choreic movements of the face, and the remedy suggested for their relief was zinc. I have had occasion once or twice to use the remedy, and thought with some good results. The case before us would seem to me to be one calling for that sort of treatment, beginning with one fourth grain sulphate of zinc, increasing the dose to such a point as his tolerance of the drug will admit. Another important point is the diet; I think the diet of this patient should be rich and liberal, and composed of such food as will improve his nutrition. Cod-liver oil, as has been suggested, might be given with benefit. I

do not know how far we could effect a cure; it is very probable that when a habit of this kind is formed it would be hard to make a positive cure.

Dr. Cottell: If this case is choreic, we may hope for relief by progressively increasing doses of arsenic. If it is due to gummata, iodide of potassium, mercury, and cod-liver oil, as suggested by Prof. Palmer, would be the thing. If it is clonic torticollis, which I take it to be, then nothing is going to cure it. I do not know why my friends, the surgeons, are so much inclined to the belief that this is a case of choreic trouble. Chorea is a disease of young life, and not of adult life. The only forms of chorea that we could have in a patient of this age are Huntingdon's and post-hemiplegic chorea, and these are incurable. Chorea does not increase in intensity by fixing the patient's attention upon any thing. A strong differential diagnostic point between chorea and paralysis agitans, leaving age out of the question, is that a man having paralysis agitans may be quiet until he attempts to do something or until he commences to talk, while in chorea the shaking is present whether he attempts to do any thing or not. I am inclined to think that this is not chorea; I wish it was, because then the prognosis would be more favorable.

Dr. Kelly: What has been the result of the operation of stretching and cutting the spinal accessory nerve? The spinal accessory is the inhibitory nerve of the heart, and the nerve of voice, having its upper origin in the fourth ventricle; the lower origin from the chord supplies the sterno-cleido-mastoid and trapezius muscles with motion. But the question I wanted to ask is, what has been the history or result of neurectomies for the relief of torticollis? Does it affect the voice or heart? Would it not be a dangerous procedure?

Dr. Cottell: Dr. Kelly has suggested an important point. I believe that stretching the spinal accessory nerve would affect both the voice and the heart. I neglected to mention, in reporting the case, that in using galvanism on this patient, whenever I would apply it over the spinal accessory nerve he would complain of a feeling of faintness.

Dr. Rodman: Concerning the effect cutting or stretching the spinal accessory nerve would have upon the voice or the heart, both these operations have been done with excellent results, and so far I have seen no mention made in works on surgery of any unfavorable effect upon either the heart or voice. I do not say that either might not have some effect. Excision of the nerve promises more than stretching; it has been followed by excellent results in many instances.

Dr. Cartledge : In the case I reported some time ago, and incidentally referred to in connection with the patient exhibited by Dr. Cottell to-night, the moment the spinal accessory nerve was severed there was a sudden and serious heart depression. This was so severe that for a few minutes we were fearful of losing the patient, but by the administration of nitro-glycerin and digitalin hypodermatically she was revived, and the operation was rapidly completed. This may have been simply a coincidence of anesthesia.

Foreign Correspondence.

LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

Vaccination in Ancient Ages ; The late Census and the Medical Profession ; Influenza ; The Medical Student as Others See Him ; Triplets ; Bullets and Infection ; Two Attacks of Scarlet Fever ; Bilirubin ; Strange Cause of Death ; Bullet Wounds of the Brain.

Recently at the Epidemicological Society Dr. Pringle drew attention to a passage which he had come across in an ancient Hindu work, which he thought proved that vaccination was known and practiced in India centuries before the birth of Jenner. "The smallpox produced from the udder of the cow will be of the same mild nature as the original disease, the pock shall be of good color, filled with clear liquid, and surrounded by a circle of red. There will only be a slight fever of one, two, or three days, but no fear need be entertained of smallpox so long as life endures." Dr. Pringle quoted several other passages from the same book.

The fact was brought to light at the last census that there were residing in England and Wales 18,936 medical men and 101 medical women. The number of female nurses was 53,057 and 601 males. Two ladies were veterinary surgeons as against 3,191 men.

Influenza is again with us. At Birmingham it has assumed an epidemic form, and many medical men are overwhelmed with the demands made upon them in consequence of the outbreak. The death-rate has risen about three per thousand, but thus far the disease appears to be less malignant than in 1891, when 204 deaths were ascribed to the visitation. Unfortunately the metropolis has never been quite free from this scourge. It figures in every weekly return as accountable for eight or nine deaths, and it seems even to defy sanitary conditions.

A correspondent, writing in a German medical paper about the study of medicine in England, thus sketches the students: "They are quiet, retiring gentlemen, obliging to a foreigner who has been introduced to them. Anybody who is acquainted with English families knows that the well-educated middle classes in England live in a comparatively unpretentious style, and that in many circles no alcoholic drinks of any kind are taken. The result of this is that drinking bouts are unknown among English students, and you never hear of men wasting two or three terms in sheer idleness. The English student takes an interest in physical exercises; he finds amusement in cricket, football, and races. Anybody who has spent some time in England will have remarked the keen interest taken by all grades of the population in the competitions between the universities and the schools. There is an athletic club also in every hospital school, which is always patronized and encouraged by the superiors. But students, many of whom are medical students, take an interest in other matters of a more serious kind. In the larger towns they form societies which devote their spare time and a good deal of money to the relief of the social misery existing there by working somewhat after the fashion of missionaries.

Coming-of-age festivities of a remarkable kind were celebrated at Whitmarsh, near Leamington, yesterday. Twenty-one years ago the wife of a cattleman, the mother of thirteen children in all, gave birth to a triplet. All three lived, and yesterday (November 13th) they attained their majority. It is stated that a case of a triplet reaching the age of twenty-one is unprecedented in England.

A number of experiments have been made to test whether bullets carry infection. The bullets infected with micro-organisms were fired into tin boxes containing sterile gelatine peptone, and in every case the infected bullets planted growths of these organisms in the gelatine. Moreover, clean bullets fired through flannel infected with the bacilli also produced corresponding growths in the gelatine, an experiment showing the danger of infected clothing in war. On the other hand, clean bullets simply fired into the gelatine produced no organisms in it except the ordinary moulds and bacteria of the atmosphere. It was proved that the heat of a fired bullet was not sufficient to destroy any bacteria on it or in the clothing through which it passed.

The Director-General of the Army Medical Department at the War Office wants forty grains of dry cobra poison for experimental purposes, and the Bombay Natural History Society is intrusted with its procurement.

Early next month the annual *conversazione* of the Royal Nurses' Association will be held in the Galleries of the Royal Institute of Painters in Water Colors. The members of the Choral Society of St. Bartholomew's Hospital, which is composed of students and nurses attached to that hospital, will provide an entertainment on the occasion, and a number of professional artists have also promised their assistance.

Dr. C. P. Childe reports an interesting case of a patient aged thirteen,

who had two distinct attacks of scarlet fever in four months. In March of this year the child had a severe and well-marked attack. She desquamated freely, and at the end of six weeks was considered well, and left home for a change of air. The rooms she had used during the illness underwent an abundant fumigation with sulphur, but there was no lime-washing or repapering. The following May she returned and occupied the same apartments as during her illness. The rooms were constantly frequented by the other members of the family, none of whom took the disease. In July the girl was again found suffering from scarlet fever, the illness being if any thing more severe than in the previous attack during the month of March; there was slight albuminuria, which, however, soon passed off. The desquamation was more profuse than on the first occasion. Dr. Childe says the immunity or resistance derived from the first attack appeared to be *nil*, the second illness being the more severe of the two.

At the Pathological Societies meeting Dr. Dickinson produced crystals of bilirubin from hydated cysts of the liver. The cyst, which had been operated upon during life, was found to contain a large number of dead collapsed hydatids, along with a fatty substance containing crystals of bilirubin. Dr. Dickinson remarked that such crystals had been frequently recognized in hydatids of the liver by Prescott Hewett in 1845, by Virchow, and later by Dr. Bristowe, who looked upon them as hematoidin. At the present time the identity of bilirubin and hematoidin was generally held; he, however, considered they were derived from the bile rather than from blood, because they were seldom seen in other hydatids than those of the liver, and that the passage of bile into the sac was most probably the cause of the death of the parasite.

Recently a man in a public house made a wager that he could place a billiard ball in his mouth and close it. The man did so, was seen to struggle, and upon removal to a hospital was found to be dead. At the *post-mortem* it was found that the epiglottis was not depressed, but that the ball lay over the upper opening of the larynx. The organs of the body were healthy but intensely congested.

Mr. Victor Horsley maintains that the cause of death from bullet wounds of the cerebral hemispheres was due to the sudden increase of intracranial pressure brought about by the entrance of the bullet into the cavity of the skull, a cavity which was closed and already full. As an experimental demonstration of this he showed that when a closed cavity filled with water and lint was fired into, the increase of internal pressure manifested itself by the bursting of the canister with great violence. The increase of pressure in the brain took effect on the respiratory center, which becoming paralyzed, death ensued.

Pediatrics.

In Charge of Henry E. Tuley, M. D.

SPORADIC CRETINISM TREATED BY FEEDING WITH THYROID EXTRACT.—(London Lancet, No. 3,662, November 4, 1893.) Dr. W. W. Ord reports four cases, with photographs, showing the children before and after treatment:

1. A female had been treated in 1892 by implantation of human thyroid gland, and improved for a time, but after eight weeks the implanted gland was practically absorbed, and improvement ceased February, 1893. At six and a half years she had never walked, but could move about the floor. General appearance monkey-like. Hair scanty, neck thick, with lumps above each clavicle. No thyroid gland could be felt. Subject to fits of passion, legs rachitic, intelligence small. Urine light color, 1008; contained no albumen. Average amount of urea 0.4 per cent. Temperature usually subnormal; occasionally it rose to normal, never above it. Thyroid gland, minced, began March 1st. This she disliked, and March 15th was given prepared powder of thyroid, the equivalent of two fifths of a gland in the twenty-four hours. This was continued for two weeks, after which she was given compressed powder in tablets of five grains each. One of these she has continued to take daily up to the present time. No ill effects followed. Her temperature for a few days rose to 99° F., but never went higher. No vomiting or lassitude. March 18th, urine contained 3.5 per cent of urea, and on March 22d 4 per cent. Physical improvement began to be manifested in about a week. The general nutrition began to improve, the skin became moist and soft, and the hair lost its harsh, dry feel. At the end of three months she began to stand alone, and at the present time can walk across the yard without assistance. The elongation of the neck is especially noticeable. She talks to her companions, and is much more cleanly in her habits. Her urine now contains 1.6 per cent of urea. She is now making an average gain of half pound per week.

2. Male, three years. Always been dull and backward, and could not speak. Began to walk at the age of two years. General habits dirty; general appearance rachitic. No thyroid could be felt, and there were no supraclavicular enlargements. The skin was dry, the temperature slightly subnormal. His temper variable. Urine very pale; average specimen showed 0.7 per cent urea. On February 24th he commenced a diet of minced thyroid gland, one sixth of a gland *per diem*. On March 15th prepared thyroid powder was given, and two weeks later this was replaced by thyroid tablets. These he has been taking daily ever since. March 21st he was passing two per cent of urea in his urine. He improved more rapidly than Case 1. His temperature never rose above 99° F. His mental and

bodily powers increased rapidly. He can converse readily. He has now lost his dirty habits.

3. Male infant aged nine months, who was first seen on March 4, 1893. He was of a typically cretinoid appearance, the facial and bodily conformity being well marked. The tongue protruded about half an inch beyond the lips, and almost filled the buccal cavity. It was slightly bifid, and there was a constant flow of saliva. No thyroid gland could be felt, and there were marked supraclavicular swellings. The child remained under treatment for a week, but owing to an outbreak of infectious disease became an out-patient. One tablet of compressed thyroid powder (five grains) was given daily, under which treatment an average rise of temperature to 99° F. was the only symptom. The tongue regained its normal size in fourteen days, general nutrition improved, he grew rapidly, and manifested signs of incipient intelligence. Unfortunately he succumbed to an attack of diphtheria in August. His improvement, however, seemed to be more rapid than that of any of the other cases.

4. Male child of nine years and a half; was admitted on May 25, 1893. Before he was two years old his parents noticed that he was "backward." In 1891 he was fitted with a support for the head, owing to spinal deformity and muscular weakness. On admission he presented the typical appearance of a cretin. His intelligence, however, was much in advance of the average case. He knew his letters, he could converse reasonably, played with toys with evident pleasure, and seemed to have a good idea of the size and shape of things. He could walk and run. His temper was capricious. There was a well-marked antero-posterior curve of the spine at the junction of the cervical and dorsal segments. The curve was rounded, and in no way angular. The legs were bowed, and the feet and hands were large. The hair was scanty, the skin dry and rough, and the nails were thick and coarse. No thyroid gland was to be felt, and there were no supraclavicular enlargements. The urine was clear, of specific gravity 1012, contained no albumen. There was, on the average, 4.4 per cent of urea. The temperature was, on the whole, slightly above normal. He commenced to take the thyroid tablets on June 8th, taking one daily, each tablet being equal to one sixth of a gland. This treatment has been continued up to the present time. His temperature was slightly higher, on the whole, after the commencement of treatment. It rose on June 18th to 104° F., owing to an attack of tonsillitis. During the summer he lost weight. His appetite improved, and general health was good. Treatment was discontinued for a week in August, but this seemed to make him weaker in body and depressed in spirits. When the weather became cooler he improved in every way, but less so than the previous cases.

Dr. A. G. Paterson gives a very minute account of a male infant first seen when eleven months old. At seven months it was noticed that the child was constipated, and that simple remedies lost their effect. It was thought he seemed backward. At nineteen months his condition was prac-

tically the same, with the exception that he had grown a little. When eleven months old there were no signs of teething. He had not had convulsions or any febrile disease. The head was large, the anterior fontanelles were very open, and all the sutures wide apart; the hair very scanty, the scalp covered with a branny scurf, the nose short, the tongue very thick, protruding; the neck very thick and short; no thyroid gland felt, but there was a slight swelling over the right clavicle. The abdomen was barrel shaped and very tense, the veins being very distinct; the hands and feet thick, the limbs hard, swollen, stumpy, and very cold and purplish. The tibiae were slightly curved anteriorly, the spine was kyphotic, the skin dry and harsh. The voice was harsh and thick when crying, for he could not say a word. There was no intelligence. The child was very anemic, the appetite good, the bowels very constipated, and the motions pale; urine clear. When nineteen months old the left occipital fontanelle was closed, and in the right a Wormian bone could be felt. The sutures were closing, the hair was more abundant, the veins of the abdomen were mostly gone; the muscular power was improving, but he could not yet sit up, and could only just move the limbs. The rectal temperature was 96° F. The mental development was improving. He now recognized his father and mother, and occasionally smiled to them. He could only drink while lying down, and only from the bottle, as all the fluid escaped when he was sitting up, owing to the size of the tongue.

At this time thyroid treatment, consisting of ten drops of the extract plain, once daily, was employed. After the third dose it was noticed that the face seemed to be smaller, the tongue was perceptibly more in the mouth, the hands were softer, and spontaneous action was greater, as was shown by his rubbing his eyes and grasping any thing held toward him. After the sixth dose the tongue had become quite flat and wholly within the mouth, and when he cried the cavity of the mouth and throat could be easily seen, which was an impossibility before. The bowels had become quite regular, and the movements of good appearance. The cold feeling had disappeared, and the temperature was practically normal. At the end of a week his limbs had become quite soft and pliable, and he could sit up with little help. He noticed things a great deal, and his color was nearly natural. At the end of a month he began to show signs of teething, and now at the end of five months he has eight teeth. He can sit up alone and crawl on the floor, is active, and tries to say a few words. When placed on his feet he makes attempts to walk. The fontanelles are closed, except the anterior, which is still slightly open. Such is the extraordinary improvement obtained by five months' thyroid treatment, where during the previous eight months the condition had remained *in statu quo*. At present (after eight months' treatment) the child has sixteen teeth, can stand, and tries to walk. He also manages to say several words.

Under the same heading Dr. J. B. Hellier reports a case with illustrations which came under his care in February, 1892, when she was two years

and four months old. She then showed symptoms of rickets combined with sporadic cretinism, the characteristic expression of the face, the "lumpiness" of the back, neck, and limbs. She cried almost constantly, and could not sit, stand, or crawl, or speak a single word. The extremities were habitually cold and bluish, skin harsh and rough, the hair being coarse, complexion sallow and pale, with a dusky tinge on the forehead and temples. There was convergent strabismus, and nystagmus was frequently observed, having been first observed at the age of sixteen months. She was under my care for a year, with simple treatment by cod-liver oil, iron, arsenic, etc. At the end of that period her condition was practically unaltered. She had four incisor teeth, and was perhaps slightly more intelligent, and could just articulate "da, da," imperfectly, but was in other points as marked an example of cretinism as ever.

February 3d she was given per mouth three days a week half a dram of thyroid extract. On February 17th the dose was altered to fifteen minims daily. March 3d the whole aspect of the child is changed; she looks sharper and brighter, and her eyelids and cheeks are less swollen. The lips are thinner, the tongue smaller, and all the myxedematous swellings throughout the body are smaller. The hands and feet are warmer. She eats better, and tries to talk. On March 17th it was noticed that she perspired a good deal, a thing which never happened before the present treatment. On the 24th the hair was coming off the occiput. She had cut another incisor and one premolar. The skin was much healthier in color. April 7th it was clear that the abdomen was smaller and the umbilical hernia disappearing. On the 14th the mother reported that the child had begun to sleep with the mouth shut. On the 21st fresh hair was growing on the occiput, and on the 28th she had nine teeth, and was gaining in weight. On May 4th there was no abnormal swelling or thickening to be observed, and the thyroid extract was discontinued for the time being. No feverish reaction occurred. The improvement in the patient began almost at once, and struck every one who had seen her previously. On June 23d her condition was as follows: The fontanelles were nearly closed, the rickety condition was less marked, there was no hernia, the abdomen was less in size, and the nystagmus was rarely noticed. The patient had twelve teeth, she was stronger, could sit, but not stand, and can only say one word. She cries less, and was sharper and brighter and more intelligent. There were no myxedematous swellings to be observed.

THE TREATMENT OF TONSILLITIS BY MEANS OF INJECTIONS INTO THE SUBSTANCE OF THE GLAND.—Prof. v. Ziemssen read a paper on this subject at the Congress of Medicine held at Weisbaden, April, 1893. Injections of a solution of carbolic acid were first recommended by Traube and Heubner in scarlatina. V. Zeimssen has found them useful in the various forms of tonsillitis, catarrhal, follicular, and phlegmonous. He was induced to try this treatment by the consideration that most cases of tonsil-

litis are caused by some infective virus. All recent investigations into the pathological anatomy of the tonsils have shown that in the follicles there are colonies of micro-organisms of all kinds; indeed, they are found in the follicles of healthy tonsils, but it appears that as long as the epithelium is healthy they do no harm. When, however, the epithelium is in any way injured they make their way into the substance of the tonsil and set up inflammation there. In the sore throat of scarlatina in severe cases there are nearly always small abscesses in the centers of the tonsils, from which foci inflammation spreads to the cervical lymph glands, and may cause general septicemia.

Von Ziemssen's treatment in cases of catarrhal tonsillitis consists in injection of seven minims of a two-per-cent solution of carbolic acid into the middle of each tonsil. He uses for this purpose a specially constructed syringe. Soon after the injection pain and difficulty in swallowing diminish, and the temperature becomes normal. Usually only one injection into each tonsil is necessary. Sometimes a second is required in order to check inflammation. It might be said that the fall in temperature was due to the natural termination of the attack. From the constancy, however, with which this fall followed the injections, and the immediate improvement of the symptoms, Von Ziemssen believes the injections check the activity of the active microbes which are causing the inflammation. The injections are easy to carry out, and do not irritate the throat.

Sahli (Berne), in the discussion which followed, stated his agreement with V. Ziemssen as to the beneficial effect of this treatment both in tonsillitis and in scarlatinal sore throat. He said that latterly, instead of carbolic acid, he had been using iodine trichloride, a strong antiseptic, yet not a very poisonous body. He uses a two-per-cent solution of this body in water, and injects one or two minims of this into the tissues in different places once or twice daily. He uses this method in diphtheria with surprisingly good results. He strongly recommends this treatment for general adoption, and adds that he uses an ordinary hypodermic syringe, and that the procedure is extremely simple and easy to carry out.—*Centralblatt f. innere Med.*, No. 25, 1893. (Resumé by Dr. A. Ernest Gallant, from Dublin Journal Medical Sciences, October, 1893.)

DIPHTHERIA: TRACHEOTOMY, PERSISTENT AND INCREASING DYSPNEA, SYSTEMATIC CURETTING OF THE TRACHEA; RECOVERY.—Dr. C. L. Scudder (Boston Medical and Surgical Journal) gives the following history of a boy four years old, ordinarily in good health, who had been ill with diphtheria for ten days. His brother, one year younger, had died of the same disease one week previously.

Very little disturbance of the tonsils and pharynx existed at the time of the first examination, the end of the second day's illness. Breathing was slightly embarrassed, as shown by the retraction of the supraclavicular and epigastric regions and dilatation of the *alæ nasi* with each inspiratory effort.

The lungs were normal, the heart was in good condition, the temperature was low. The indication *par excellence* for operation was present, namely, increasing difficulty of breathing.

Tracheotomy was done with instantaneous relief. The boy was kept in an atmosphere steam-laden. On the second day after operation the secretion from the tube became a little sticky and slightly diminished in amount. This improved upon the use of a spray close to the tube. The third night the secretion became very slight, the respiration rapid and labored, and the child cyanosed and extremely tired by the tugging for air.

In spite of removal of both tubes and dilatation of the wound, the use of a catheter through the wound, and the introduction of a feather, and later a pair of forceps, no relief was afforded. The child was fast losing strength and was rapidly becoming asphyxiated. A dull wire intra-uterine curette was introduced into the wound, gently carried to the bifurcation of the trachea, and all sides of the trachea, its whole circumference, systematically and thoroughly curetted. Pieces of membrane, one of which made a complete cast of the circumference of the trachea, were withdrawn through the wound. The hemorrhage was slight. The relief to the dyspnea was immediate. The tube was replaced, and the boy recovered.

Two years have elapsed since the tracheotomy and curetting of the trachea. The boy is well and strong. The maneuver was suggested by Dr. Wheeler, of Chelsea, Mass., who had a similar case which he had curetted. The author believes that it would seem wise to curette after tracheotomy, if dyspnea increased in spite of all ordinary precautions, and if the patient is in good general condition, but not to neglect this measure until the child is exhausted by difficult breathing and by sepsis. No other similar case could be found on record.

IN THE SUMMER DIARRHEA OF CHILDREN Dr. Stuart Patterson (Pittsburgh Medical Review, August 19th.) employs magnesium sulphate. In the cases mentioned by him the ages ranged from one to six years. The dose and mode of administration of the remedy were as follows: The mother was directed to give to a child a year old an even teaspoonful of sulphate of magnesium, sufficiently moistened to swallow, as soon as she arrived at home, the process to be repeated in the morning, and the child to be brought back to me at 3 P. M. on that day, that being the hour of my service at the dispensary. This procedure was repeated daily at the same hours till the discharges became *yellow*. For the older children the dose ranged from a heaping teaspoonful to a heaping tablespoonful. The after-treatment consisted of general tonics and prophylactic precautions. The former were selected according to the necessities of each case. Those most frequently used were syrup of iodide of iron, cod-liver oil, compound syrup of hypophosphites, strychnine, quinine, pyrophosphate of iron, etc.—*College and Clinical Record*.

Abstracts and Selections.

TUBERCULOUS PLEURISY.—Inasmuch as at this time the attention of medical men in all countries is being more than ever attracted to the etiology and pathogenesis of the inflammations of the serous membranes in general and of the pleura in particular, the delivery at Boston of the Shattuck Lecture upon the subject of "Tuberculous Pleurisy," by Professor William Ostler, of Baltimore, has come most opportunely. Whereas a few years ago clinicians carried to an extreme the idea that nearly all of the so-called idiopathic pleurisies were tuberculous in origin, at the present time and with the reaction following on the more exact bacteriologic researches, there is a tendency perhaps to ascribe to other micro-organisms, for example, the micrococcus lanceolatus, too important an etiologic rôle.

As the field of medical knowledge grows wider, old facts reappear before us disguised in a different garb; we look at objects through tinted spectacles and are prone to give them color and shape from our glasses, only too often to the misrepresentation and distortion of what actually exists. It is at these times that we need the calm and impartial judgment of the experienced observer to correct our visual aberrations, and to prevent us, as the transformation proceeds, from losing sight of old and well-established truths in the rush after new ideas and conceptions.

The Shattuck lecturer for 1893 has based his remarks upon the firm foundation of observed facts, and has combined with ample illustration of the different clinical types a careful description of the pathological changes found in the different forms of tuberculous infection of the pleura.

That a large percentage of cases of pleurisy are definitely tuberculous he shows by an analysis of 101 successive cases of pleurisy that came to autopsy. There were in 32 fresh miliary granulations, caseous masses, or diffuse fibro-tuberculous membranes. In 11 of these there were miliary tubercles in the pleura; in 8 there was empyema (singularly enough in every instance associated with pneumothorax), and in 13 the exudation was sero-fibrinous and the pleural leaflets were more or less thickened.

Clinically, the tuberculous pleurisies are divided into two great classes: (1) The acute tuberculous pleurisies, and (2) the subacute and chronic forms. The acute variety includes three distinct groups: (a) Acute tuberculous pleurisies that subsequently run a chronic course. In these the onset may be abrupt and resemble a pleurisy *a frigore*, the patient being of good physique and of good family history. The subsequent history alone clears up the case. (b) Secondary and terminal acute tuberculous pleurisies in which miliary tubercles appear in the pleura as a result of direct extension, almost always from foci in the lung, and not necessarily associated with general

miliary tuberculosis. That not all pleurisies terminating in pulmonary tuberculosis are tuberculous is shown by 11 of the 101 cases in which the causes of the pleurisy were organisms other than the tubercle bacillus. (c) One of the most interesting of all the forms described is the acute tuberculous suppurative pleurisy, in which there are in the pleura ulceration and suppuration due to the tubercle bacillus. These cases have actually been looked upon as instances of mixed infection with pyogenic organisms, but in a case of multiple abscesses in the pleura in a young girl, reported by the lecturer, cultures made from the pus remained sterile, while cover-slip preparations showed an extraordinarily large number of tubercle bacilli. This favors the theory that the tubercle bacillus sometimes acts as a pyogenic organism, but until further examples are recorded it will probably be safe to still regard such cases as instances of mixed infection, the sterile cultures perhaps being accounted for by the death of the pyogenic bacteria before the death of the patient. In any case this type of acute tuberculous pleurisy must remain a most interesting and important one.

Turning to the subacute and chronic forms, Dr. Ostler divides these also into three groups: (a) Those with a sero-fibrinous effusion, which may be primary (when they are prone to be particularly insidious and are likely to be overlooked), or secondary to lung-tuberculosis, when they are as a rule easily diagnosticated; (b) those with a purulent exudate, when the onset is subacute, and the course is chronic and latent, usually associated with pneumothorax; and (c) the chronic tuberculous adhesive pleurisies, the special feature in these being the extensive, sometimes enormous, thickening of both layers of the pleura.

Attention is drawn to those less usual cases of general tuberculosis of the serous membranes that present a fairly distinctive clinical type, in which the infection attacks the serous membranes one after another, or in which the pleura and peritoneum, and at times the pericardium, may be affected almost simultaneously. The clinical classification of Boulland is closely followed here, and the obscurity of the affection, together with the protracted course, with periods of improvement and often with little or no fever, are dwelt upon. All of the clinical types are illustrated by protocols of cases that have been under the lecturer's observation.

Passing on to the general pathology of the tuberculous pleurisies, Dr. Ostler deals at considerable length with the avenues of infection, describing the different routes by which the tubercle bacilli gain entrance to the pleura. The majority of cases, it would seem, arise through direct infection from the lung, a superficial focus there extending directly to the pleura. In very many cases, however, including those of primary tuberculous pleurisy, the bacilli reach the pleura through the lymph channels, by inhalation and deposition on the mucous membrane and transportation along with dust particles through the interstitial lymph spaces, or by infection through the lymph channels from the neck (scrofulous glands, carious bones), or by the extension upward from the peritoneum to the diaphragmatic pleura.

While in some cases the diagnosis is easy, in many it is extremely difficult to decide that a given pleural exudate is positively tuberculous—a fact which is not surprising when we consider the very diverse clinical variations met with. The appearance of the individual, his previous history and that of his family, the mode of onset, the course of the affection, and the character of the exudate—all have to be carefully considered, but often none of them may even be suggestive—or when they lead to suspicion may be misleading. We are recommended to carefully inspect the different groups of lymph glands contiguous to the pleura, and to examine the expectoration of the patient repeatedly for tubercle bacilli. The bacteriologic examination of the exudate, which has been so much insisted upon of late, is fully dealt with, and when inoculations into ordinary culture-media remain sterile there is presumptive evidence in favor of a tuberculous pleurisy. The examination of cover-slip preparations, except in the case of a purulent exudate, rarely permits the demonstration of tubercle bacilli. The inoculation of guinea-pigs with portions of the exudate probably offers the best chance of determining their presence or absence. In cases of empyema a tuberculous process is often complicated by infection with ordinary pyogenic organisms.

The diagnostic value of injections of tuberculin is regarded as very uncertain, and a case is reported in which a marked reaction followed such an injection, the autopsy subsequently showing the case to have been carcinomatous and not tuberculous at all. The diagnosis in the chronic forms, with sero-fibrinous exudate and thickening of the pleura, in which there is persistent flatness at the base of the lung, is peculiarly difficult, but the recurrence of an effusion in spite of frequent aspirations should make us suspect a tuberculous process.

The limits of this article will not permit us to more than mention the therapeutic suggestions laid down. The indications are twofold: (1) To limit and control the exudate and to endeavor to promote absorption, and (2) to improve the general condition of the patient and increase his powers of resistance, in order if possible to bring about healing of the tuberculous lesions. After the acute stage is over, during which rest and dry diet are desirable, repeated aspiration being resorted to if necessary, we are to endeavor to promote nutrition by careful feeding, a well-ordered life, perhaps by a change of climate, and by the exhibition of suitable tonics. Pulmonary gymnastics may be of value when there is retraction of the chest. The purulent cases, in which the condition of the patient permits, are of course to be turned over to the surgeon for evacuation and thorough drainage. The lecture is brought to a close with a quotation from Sir Andrew Clark: "When we have a patient with basic fibrinous pleurisy let us hold him fast, restrict his freedom, and treat him carefully until every remnant of it is gone."—*Medical News*.

THE BACTERIA OF THE SURFACE.—At the annual meeting of the Mississippi Valley Medical Society, held at Indianapolis, Ind., October 4, 1893,

Dr. Frank J. Thornbury (University of Buffalo) read a paper under this title, in which the latest researches were set forth, the rational mechanical means of disinfection summarized, and the non-utility of antiseptics asserted. The varieties of organisms which the cutaneous and mucous surfaces contain in myriads comprise molds, yeast, fungi, bacilli, cocci, color, and odor, producing bacteria. Inhabitants of every land and every region, in every occupation, have their characteristic germs nesting upon them. The hairy regions, as the axillary space and genitalia, and the interdigital folds, are the places of predilection for the bacteria upon our cutis. Myriads of germs are present in the oral cavity, in the entire intestinal tract, the genital tract of the female, the male urethra, and in the conjunctival secretion and cerumen of the ear.

Among the masses are germs which are pathogenic, as the Fehleisen streptococcus of erysipelas. The cleansing of the surface constitutes one of the most important duties of asepsis. This pertains especially to the physician's own hands. The disinfection can not be accomplished by the use of antiseptics so called, which do not even reach the bacteria imbedded in the substrata of fat and dirt. The number of bacteria remain practically unaltered after the ordinary submersion of the hands in sublimate. The disinfection must be mechanical, the glandular secretions, dead epidermal cells, vegetable and animal substances being dissolved away. For the latter purpose soap, hot water, and brush are used, aided by alcohol and ether, and rubbing with sterile towels.

Baths are an important adjunct to the aseptic arrangements, and one or a number of baths should be administered previous to operation. The razor should be used freely for removing the hairs upon which many germs aggregate, and for disposing of the superficial epidermis, which is heavily impregnated with micro-organisms. The lubrication of the hands may be of advantage in vaginal and in rectal examinations and in the making of autopsies, to prevent dissemination of any remaining germs and avoid contamination. The mucous membranes are the most difficult of disinfection.

The most powerful antiseptics are here worthless, as in case of the skin. The irrigation of the vagina with 1 to 1,000 bichloride has not the slightest influence upon the bacteriological condition. The use of antiseptics is more or less hazardous. In case of the rectal mucous membrane death might result from rapid absorption of the injected fluid. Irritation, catarrh, erosion, or some degree of intoxication are common consequences. Irrigation with water or some mild solution, the mechanical removal of the mucous and dirt by the fingers, aided by cotton and gauze pledgets, are our only remaining resources. It is easy to understand, therefore, that an absolute disinfection of the mucous membranes, such as we are able to practice upon the skin, is impossible.

Preceding operations upon the intestinal tract, free purgation should be practiced; in case of the stomach, irrigation. All the articles used in the disinfection should be sterilized; the gauze, cotton, and towels should be

sterilized in steam, the brushes and nail scrapers in one-per-cent sal soda solution.

We must require a guarantee that the soap has been boiled in the process of its manufacture, otherwise it will contain many germs. The brushes, with their contained moisture and albuminous substances, are genuine culture habitats for microbes; they may be dangerous articles, and require the most particular attention. The brushes should be submerged continually in one-half-per-cent sublimate solution, in enameled receptacles, besides being sterilized when heavily contaminated.

GANGLION.—The frequency with which ganglion occurs, the disabling annoyance it causes, and the tendency it has to return after the usual treatment by rupture are well known and need no comment. There has been, however, much looseness in the use of the term, and many cases of tenosynovitis have been classed and treated as ganglion. This is unfortunate in two ways. The treatment of a synovitis should be by rest, a ganglion by quite other means; and to confuse the two is to maltreat the patient and spoil statistics of either case.

Jordan has made a detailed report of twenty-five cases of ganglion recently under his care. He includes in his list only cases of true ganglion, that is, a small cyst connected with the sheath of a tendon, unconnected with any of the more superficial structures; the sac consisting of a fibrous capsule lined with synovial membrane. The cause of the affection he believes to be in almost every case a hernial protrusion of the synovial membrane through a slit in the sheath of the tendon with a subsequent compression of the neck and closure by plastic inflammation from the rest of the synovial cavity.

Of the various methods of treatment none have been so successful as could have been desired. Rupture, electrolysis, puncture, excision—all have well-known objections, either an insufficient cure or undue exposure of the tendon sheath to inflammatory action and obliteration. He has found the most successful results from the aspiration from the sac of ten to sixty minims of the fluid and the injection of the same amount of Morton's fluid without removing the needle. The sac was rubbed to insure thorough contact, and the hand then put upon a splint and padded for five days. The previous failures from injection he attributes to too weak a fluid to cause sufficient inflammation, or to so strong a solution that it becomes surrounded by a layer of coagulated lymph before it touches the walls of the sac itself.

Of his cases twenty-three occurred in women, of whom seventeen were washerwomen or house-servants who have hard manual work to perform, and a considerable amount of "wringing" to do—the very kind of work that would be likely to lead to a hernia of the synovial membrane. Twenty of the ganglia occurred on the tendon of the extensor communis digitorum, one each on the extensor carpi radialis longior, extensor communis digito-

rum, extensor secundi internodii pollicis, peroneus longus and flexor longus pollicis.

The duration of the affection had been from six weeks to six years. The average amount of fluid withdrawn was thirty-eight minims, and of the injection about twenty. Several of the cases had been ruptured or otherwise treated before. None suffered any discomfort and all were reported well, with no return after the end of twenty-one months.—*Boston Medical and Surgical Journal*.

INTERLOBAR PLEURISY.—D. Gerhardt (*Berl. klin. Wochenschrift*, August 14, 1893.) refers to the infrequency of this disease. It begins sometimes suddenly and at other times more gradually, with pain in the side and difficulty of breathing. Usually the fever is high and intermittent. There may be no abnormal physical signs or only a few *râles* or altered breath sounds. Some dullness may be present, extending from the third or fourth dorsal spine outward and downward, the note above and below this perhaps being more resonant. Thus the signs of a typical pleural effusion may be absent. Suddenly the sputum becomes purulent and often ill-smelling, and the patient may be well in two or three weeks, or it may take longer. In a few severe cases death has resulted from septicemia. Case: A man, aged thirty-four, was suddenly seized with pain in the side, dyspnea, and shivering. Later a patch of dullness was found in the right axilla. This extended subsequently to the scapular line, and in front to the mammary line. The temperature was fluctuating, and at times there was shivering. A fortnight after admission there were violent attacks of coughing and abundant purulent expectoration. A few days later pus was found by exploration. The temperature began to fall with the appearance of the purulent expectoration, and the patient was better, so that thoracocentesis was delayed for a little time. It could not be decided whether it was an interlobar or a basal empyema. As the patient ceased to improve, the chest was incised and a piece of rib removed ten days later, a liter of fetid pus being let out. The patient died some days later. The pus lay in a cavity between the lobes of the right lung, the lung being strongly adherent to the chest wall. Sometimes tubercle, less frequently pneumonia, have been causes of this form of pleurisy. A patch of gangrene in the lung might also produce it. For exploration in these cases long needles must be used. The communication between the bronchus and empyema cavity could not in this, as in some other recorded cases, be found. Most published cases have recovered without operation, the pus having been spat up. This may be a reason for delay until rupture occurs. If the pus lie near the chest wall, it should be let out, as in other empyemata; but if it be found deeply placed by the long exploring needle, one may be glad to delay the opening as long as possible. If, however, the patient's condition shows no improvement, the operation must be done.—*British Medical Journal*.

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D. W. YANDELL, M. D., and H. A. COTTELL, M. D., Editors.

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THE MURDEROUS CRANK AGAIN.

Some issues since we ventured an editorial upon the medico-legal features of the impending trial of the crank who at the close of the World's Fair gave himself immortality in the annals of crime by murdering in cold blood the mayor of Chicago.

Upon that occasion we remarked that the farce enacted in the trial of Guiteau for the murder of President Garfield would probably be repeated in the coming case, and indulged in some reflections which seemed to be germane to the question.

We claim no prophetic facility beyond the light which the lamp of experience may throw into the future; but recent developments seem to prove the forecast clear. Among the evidences of this is an article in the Medical and Surgical Reporter of November 25, 1893. The learned editor says:

* * * * *

The daily papers report that a thorough medical examination shows the assassin of the late mayor of Chicago responsible for his acts. This is as it should be so far as our information goes and relying on general principles.

There is one phase of the question which it is desirable to take into consideration. An author, writing for the Open Court, presents the very sound view that the theory of political assassination is a justification of private murder. The recent expression called out by the murder of Mayor Harrison is but the echo of his words written when Alexander II was

killed by the explosion of a Nihilist's bomb. He then said: "Once admit the right of assassination as a remedy for political evils, and there will always be somebody under sentence of death, a mark for the private executioner. It is the menace of death to every man above the grade of a tramp."

This is a logical and an absolute statement. Deductively, therefore, they who advocate the murder of a sovereign, ruler, or governor are promoters of assassination, which is very little different from being accomplices to murders committed in pursuance of those theories of political assassination. The man who incites to crime is as guilty as the man who commits the crime. That has always been held in the case of hired assassination. The man who gives another a certain sum to do a murder, or promises him a material reward on the execution of the deed, is a principal to the murder. Now, it does not make much difference what the nature of the reward may be, whether it be money, food, or the assurance of a better condition. The incentives to murder may be as different as are the varieties of murderous actions.

* * * * * * * * *

There is a responsible insanity. If we hang some of the so-called "cranks" whose "insanity" takes the form of killing the men who displease them, we will have fewer assassinations. The example of the gallows uncompromisingly employed is a superb check upon the exhibition of homicidal crankiness. Cranks can reason very well in the eye of the gallows.

This would all be pretty logic if it could be proved that Guiteau or Prendergast could have had any sane criminal incentive for his deed; but such does not appear. The analogy found in the murder of Alexander II of Russia, and the doings in general of anarchists and communists, is also too far fetched to fit the present case.

Neither of these cranks nor any similar ones were anarchists, communists, or the employes of any sect or society whose interests could be enhanced by the taking off of the murdered men. When arrested these men talk sanely about many things; but when called upon to give a reason for their crimes, their language is illogical rubbish, and nothing more.

Hearing this and perceiving the absence of any logical incentive to the crime, it is difficult to see how any expert can declare that the murderer was sane when he made the fatal shot or thrust without stultification, or how a judge and jury can turn such a man over to the executioner except by travesty of justice.

That it is expedient to rid society of the murderous crank element can not be disputed, and we believe that some special legislation is

needed for the purpose; but to attempt to give scientific warrant to a trial which seeks to make these creatures appear sane, that the death sentence may be passed upon them, is a work which our alienists ought to decline.

The papers say that some of the Chicago medical experts, to their credit be it said, have already declined on scientific grounds to take part in the prosecution as special experts in the Prendergast trial.

WILLIAM MANDEVILLE GRIFFITHS, M. D.

This accomplished young physician died at his residence in Louisville on the night of the 24th inst. of heart failure incident upon an attack of *la grippe*. Dr. Griffiths was the son of the late Dr. Thomas J. Griffiths, for many years surgeon of the U. S. Marine Hospital at this port, and a prominent practitioner.

He was born in February, 1855. He received his literary education in the public schools of Louisville, and, studying medicine in the Medical Department of the University of Louisville, graduated from this school in 1876.

Soon after this event he was appointed assistant surgeon to the U. S. Marine Hospital, the duties of which, with those of a constantly growing practice, engaged his time till the day of his death.

Dr. Griffiths was learned in his profession, cultivated in general literature, witty and ready in conversation, a genial gentleman, and a faithful friend. His untimely death extinguishes a light whose luster betokened a brilliant future.

The following is evidence of the esteem in which he was held by his professional confrères:

LOUISVILLE, December 26, 1893.

A meeting of the physicians of the city was held this morning, in the rooms of the School Board on Walnut Street, in respect to the memory of Dr. William M. Griffiths, whose sudden death on Sunday evening carried sorrow to a large circle of his professional associates in this city and elsewhere.

On motion, Dr. T. P. Satterwhite was called to the chair, and Dr. Ewing Marshall was made secretary.

The meeting was attended by a large number of the profession, and was addressed by several members, paying tribute to the high professional

character and attainments of the deceased. On motion, a committee was appointed to prepare suitable resolutions expressing the high esteem in which the deceased was held by his professional colleagues, and the sorrow universally felt at his untimely death. The meeting then adjourned. The following are the resolutions:

Resolved, That the sudden death of our esteemed colleague, Dr. William M. Griffiths, in the vigor of early manhood, has deprived the profession of this city of one of its most capable, honorable, and useful members.

Resolved, That it is appropriate to publicly acknowledge our appreciation of his worth, his manly character, and his genial fellowship.

Resolved, That we express our sincere regret and heartfelt sorrow at his death.

Resolved, That we tender to his sorrowing family an expression of our profound sympathy in this hour of deep affliction.

Resolved, That a copy of these resolutions be sent to the bereaved family, and published in the medical journals and the local daily press.

P. G. TRUNNELL, M. D.,

L. S. MCMURTRY, M. D.,

A. MORGAN VANCE, M. D.,

Committee.

Notes and Queries.

ARTICULAR AFFECTIONS IN SYRINGOMYELIA.—Graf (*Beitrag zur klinischen Chirurgie*, Band 10, Heft 3,) analyses thirty-five cases of joint disease associated with syringomyelia. This collection includes four original reports of cases lately treated by Professor Bruns. A morbid change in one or more joints occurs more frequently in syringomyelia than is generally imagined, certainly in not less than ten per cent of the cases. Of the subjects of the cases collected by the author, twenty-six were males. Syringomyelia, however, it is pointed out, attacks two males for one female. The articular complications commence at an early stage of the nervous disease, and before the complete development of muscular atrophy and sensory disturbances. A remarkable distinction between this nervous joint affection and tabetic arthropathy is its more frequent appearance in the upper than in the lower limbs. Of fifty-one joints affected in the thirty-five collected cases, thirty-nine were in the upper and twelve in the lower limbs. In tabes, on the other hand, eighty per cent of the affected joints are those of the lower limbs. This, it is stated, can be readily explained by the fact that in syringomyelia the cervical and upper dorsal portions of the cord are those chiefly affected. The

clinical and pathological characters of the joint affections in syringomyelia resemble in many respects those presented in tabetic arthropathy. In the former disease, however, extensive exudation is less frequently noticed, and the course of the arthropathy is more chronic than it is in tabes. In syringomyelia the patient still retains tactile and muscular sensibility, but has little if any feeling of pain or of differences in temperature. The author finds much difficulty in accepting any of the views that have been expressed concerning the causation of articular affections in association with central nerve disease. In syringomyelia ataxy and analgesia are not characteristic symptoms, and the morbid changes in the affected joints persist in spite of prolonged and complete rest. The direct dependence of the joint disease on the disease in the cord is opposed by the facts that syringomyelia is not always accompanied by arthropathy, and that in many cases in which arthropathy co-exists one joint only is affected. Future investigations in fatal cases of syringomyelia will, it is thought, account for this association of medullary and articular lesions by the discovery of indications of neuritis and atrophy of the peripheral nerves.—*British Medical Journal*.

RELAPSING INFECTIVE JAUNDICE.—Soupault (*Arch. gen. de Medecin*, August, 1893,) says that this form of jaundice recently described is a general disease, with a special localization in the liver. He relates the case of a lad, aged eighteen, who had a previous attack of jaundice five years ago. Eight days previously he was seized with vertigo, tinnitus, and faintness. The next day he vomited, and from this time he suffered from headache and pains in his limbs. On April 16th he was in a typhoid condition, with dry mouth and anorexia. There were no spots and no splenic or hepatic enlargement (T. 39.5°, P. 92). The urine contained a cloud of albumen. The other organs were healthy. On April 17th slight jaundice appeared, and this rapidly deepened. Three days later the stools were colorless. He then began to improve. Urine was excreted in large quantities. There was much wasting. He relapsed in a week's time, the fever reappearing, but in three or four days he was well again, and was discharged on May 13th. The illness corresponds to that described as Weil's disease. There is a pre-icteric stage, in which the symptoms resemble enteric fever, and then jaundice appears. At this time there may be epistaxis, albuminuria, hepatic pain, and splenic enlargement. The irritated hepatic cell excretes in excess, and the bile can not all be eliminated. Seven to eight days after the onset of the icterus the stools may become colorless, owing to a consecutive obstruction of the common bile duct. Some look on the relapse as characteristic. The prognosis is good, death rarely occurring. The staphylococcus, streptococcus, *B. coli communis* have been described as the cause of this disease, and the staphylococcus albus was cultivated from the blood in this case.—*Ibid*.

THE DOCTOR'S LAMENT TO HIS LADY-LOVE.

BY F. E. DANIEL, M. D.

Your life leads down by peaceful, tranquil rivers,
Whose shady bank the cool sea breeze invites;
While mine, alas! is spent 'midst torpid livers
And similar sad and melancholy sights.

To you the perfumed air is rich with sounds
As sweet as when first Sappho's harp was strung;
While I in sun and dust must take my weary rounds
To feel a pulse or view a coated tongue.

The choicest books beguile your leisure hours
And soothe to sleep or wake to kindly tears;
But woe is me! I spend my feeble powers
'Midst fever's fervid heat or checking diarrheas.

You sleep in peace on soft and downy beds,
And dream, perhaps, of flowers in sunlit lands;
While I, alas! am soothing aching heads,
Or humbly giving aid by pulling hands.

Your lovers kneel in rapturous adoration,
And tales of love in dulcet measures pour;
While creditors are my abomination,
And pauper patients daily throng my office floor.

Thy gentle pen anon the choicest thoughts indict
That dwell within thy gentle breast, or tender memory fosters;
Prescriptions I with stubby pencil write,
"Recipe, misce et fiat haustus."

Riches I bring thee not, to pride's exactions fill,
Nor offer thee, as I could wish, a handsome marriage portion;
Wilt thou despise my only store—a pill,
Or deign to take, perchance, a pharmaceutical lotion?

Alas! alas! my lady-love, I tire indeed of these
Old scaly scalps of seborrhea and eczematous hands;
Let's trim our sails to catch an outward breeze,
And endosmose in pleasant foreign lands,

Away beyond the seas, on some peaceful star-lit isle,
Where rhythmic wavelets break on coral strands,
There'll be no more of fever, pus, nor bile,
As down the happy years we'll pull each other's hands.

[*Texas Medical Journal*, October.

BICYCLE KYPHOSIS.—One evil traceable to bicycling is the confirmed stoop which has already declared itself in many wheelmen, a result so common in the less strongly built bicyclists of the continent as to have found its way into classification as the "kyphosis bicyclistarum." The dorsal curvature posteriorly, which used to be rare in boys under fourteen years of age, is, now that the bicycle is so largely used, very frequently met with, particularly among those young bicyclists whose spinal column is developing more rapidly than the ligaments and muscles, and in whose case, therefore, the equilibrium between those parts is more or less disturbed. Were it merely unsightly deformity, the stoop in question ought to be combated in every way; but confirmed dorsal curvature posteriorly has consequences of its own quite mischievous enough to call for immediate counteraction. The displacement, embarrassed functional activity, and arrested or diseased development of the organs which kyphosis inevitably induces, are all too serious to warrant the slightest neglect in remedying them. Exercise of a kind to accustom the spinal column to an action directly antagonistic to the inclination forward of the bicyclist's attitude is what is needed. The use of the Indian clubs or such similar means of incurvating the spine anteriorly, throwing out the chest and maintaining the head erect, should be practiced with that object. All the undoubted advantages of bicycling may thus be retained, without that cultivation of the stoop which tends to take a cubit from the stature of its inveterate exponents, and to impose a hunch-backed development on what it would then be a figure of speech to call a rising generation.—*Lancet*.

TWO NEW MEDICAL JOURNALS.—"Mathews' Medical Quarterly," devoted to Diseases of the Rectum and Gastro-Intestinal Diseases, Rectal and Gastro-Intestinal Surgery, Joseph M. Mathews, M. D., Editor, Henry E. Tuley, M. D., Assistant Editor and Manager, Louisville, Ky., will be issued as soon as possible after January 1, 1894. Address P. O. Box 434, Louisville, Ky.

"The Physician's Magazine," a Monthly Chronicle of the Advances of the Medical Sciences, edited by Robert C. Kenner, A. M., M. D., Louisville, Ky., and published by Geo. F. Russell & Co., 808 First Street, Louisville, Ky., will be issued on January 1, 1894.

THE MEDICAL NEWS VISITING LIST FOR 1894.—This popular visiting list is presented to the profession for the approaching year in forms of improved attractiveness and usefulness. It is published in four styles: weekly, dated, for thirty patients; monthly, undated, for one hundred and twenty patients per month; perpetual, undated, for thirty patients per week per year, and perpetual, undated, for sixty patients per week per year. Price in any style, \$1.25. For subscribers to the Journal or News, 75 cents.

Special Notices.

EUROPHEN IN RECTAL ULCER AND KRAUROSIS.—In "Notes for Practice" Dr. Waugh writes as follows in the *Times and Register* of July 1, 1893: "The value of euophen was strikingly developed in a lady aged twenty, who complained of morning diarrhea. Digital examination revealed a deep, sensitive ulcer within the sphincter ani. I ordered euophen ointment, to be applied twice daily with the finger, the bowel to be washed out nightly with a pint of hot water in which was dissolved half a dram of sulpho-carbolate of zinc. Internally I gave three pills of one grain each of iodoform. Within two weeks the ulcer had cicatrized. In kraurosis or atrophy and dryness of the mucous membrane of the vagina the writer stated that the only remedy previously known was phenic acid. The author employed euophen ointment (thirty grains to one ounce of lanolin) with uniform success. In the first case intercourse had been painful for seven years. On the application of euophen tenderness at once began to subside, and in a few weeks coitus was no longer unpleasant. Complete recovery ensued. The next case was of a lady suffering from great pain at the menstrual period, pain in the back, and continuous hyper-excitability. Faradization of the back was employed, together with euophen ointment as in the preceding case. In two months the cure was complete. The third case was that of a woman who had suffered from kraurosis during the eight years of her married life. Euophen ointment effected a cure in four weeks.

FOR THE TEETH.—One of the most skillful dentists in New York gives these rules for the care of the teeth: "Use a soft brush and water of the temperature of the mouth. Brush the teeth up and down in the morning, before going to bed, and after eating, whether it is three or six times a day. Use a good tooth powder twice a week, not oftener, except in case of sickness, when the acids from a disordered stomach are apt to have an unwholesome effect upon the dentine. Avoid all tooth pastes and dentifrices that foam in the mouth. The lather is a sure sign of soap, and soap injures the gums, without in any way cleansing the teeth. The very best powder is of precipitated chalk. It is absolutely harmless, and will clean the enamel without affecting the gums. Orris root or a little wintergreen added gives a pleasant flavor, but in no way improves the chalk. At least a quart of tepid water should be used in rinsing the mouth. A teaspoonful of listerine in half a glass of water, used as a wash and gargle after meals, is excellent. It is good for sore or loose gums, it sweetens the mouth, and is a valuable antiseptic, destroying promptly all odors emanating from diseased gums and teeth. Coarse, hard brushes and soapy dentifrices cause the gums to recede, leaving the dentine exposed. Use a quill pick, if necessary, after eating, but a piece of waxed foss is better. These rules are worth heeding. Be assured of the genuine listerine by purchasing an original bottle."

HOW TO ADMINISTER TINCTURE OF IRON.—Owing to unpleasant features, we had for some years nearly ceased to prescribe the tincture of the chloride of iron, using in place of it some other of the many ferruginous preparations. We were assured by Dr. Joseph W. Bryant, of New York, that if we would use Tarrant's Seltzer Aperient as a vehicle we would overcome the objection to tincture of iron. We have found it an immense success, and almost never prescribe any other form of iron, and *never* in any other way.—*Massachusetts Medical Journal*, December, 1893.

DR. GORDILLON, St. Armand, France, says: "I have tried Aletris Cordial in a case of dysmenorrhea. The result I obtained from the use of the preparation was excellent, far better than I had obtained in the same patient by prescribing the usual remedies employed in such cases."

